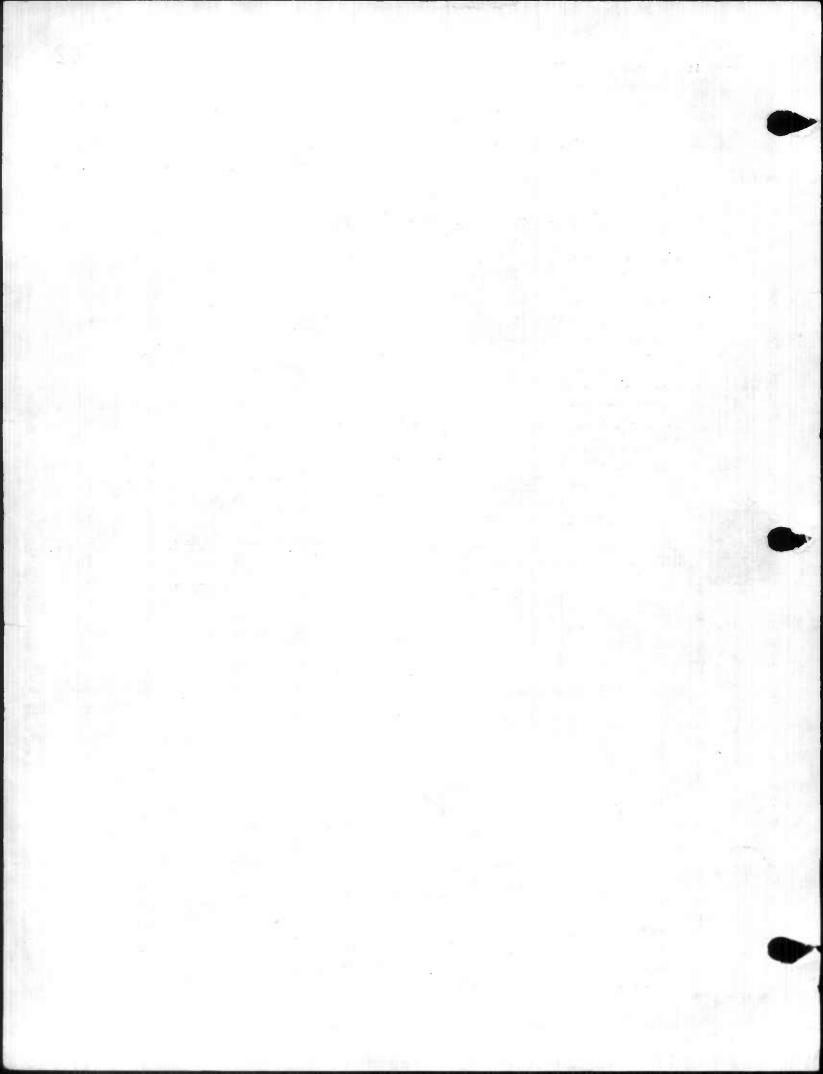
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 1, 2 5 0 1

Physician	1.	Decedent's Name (First, Middle	, Last)			ertificate of		2. Date of De	Reg. No. ath		3. Time of Death
		JOSEPH	ZEV	TET.				Month DECEMBI	ER 24, 1	Year 999	5:45 A.M.
/Medical Examiner	48	Facility Name (If not institution,				4	4b. City, Town, or				0,10 11111
CAGITITICS	н	HEBREW HOME OF	GREATER	WASHING	STON		ROCKV]	LLE	MON	TGOME	RY
Funeral Director		Social Security Number 102-07-1480	6. Sex ABM 2□F	7. Age (In yrs. 88	last birthda; Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y. Year) 0, 1911	9. Birthple Count POLA	ace (State or Foreign
THE LA	-	sual Residence of Decedent  Da. State 10b. County		10c. City	v. Town or I	Location				10	d. Inside City Limits
rector			GOMERY		ROCKV						XXYes 2 No
Director	10	De. Street and Number	COLITACE		IMOTIV	10f. Zip Code			10g. Citizen of W	/hat Count	rv?
		6121-MONTROSS	BOAD				852		UNITE		ATES
by Funeral		Maritel Status     Never Married 2 Marrie     Widowed 4 Divorced	12. Wes Dece Armed For	2∰ No e	S. 13	. Was Decedent of H If Yes, specify Cubs 1 Yes 2 No	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rece Bleck Specify.	- America k, White, e	
Completed		15. Decedent' (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired EL SALES	duning most of wa	rking	16b. Kind of Bu		ustry
		7. Father's Name (First, Middle, L	act)				19 Mothar's No	me (First, Middle	Maiden Sumem	o l	
o Be		SAM ZEMEL					ROS			٠,	
2		9a. Informant's Neme/Reletionsh	ip (Type, Print)		19b. Ma	iling Address (Street				State 7in	Code)
To Be C	1		CKWELL/DAI	JGHTER		Carlotte Control of the Control of t		ROCKVILL			20850
once.	20	Da. Method of Disposition  Disposition  Cremetion  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition		State	ametery, cr	position (Name of ematory or other place EMORIAL CI		12/26 1999 STEIN	20c. Location -	City or Tov	
an ral		Enter the disease, or a hock, or heart tailine. List o	only one cause on e	ach line.		nter the mode ot dyin		c or respiretory a		1	Approximate Interval Between Onset and Death
Examiner	re	equentially list conditions, any, leading to immediate ause. Enler Underlying ause. Enler Underlying ause. (Disease or injury	a	Due to (o	ras a cons	equence of):  ALTGE equence of):	ns E	418		1	
edicai	th	ause. Enter Underrying ause (Disease or injury lat initiated events builting in death) Last	c	Due to (or	as a conse	equenca of):				1	
lan/M			d								
ysician/M	Pa	art II. Other significant condition	d	ath but not resu	ulting in the	underlying cause giv	en in Part I.	23b. Did	tobacco use cor	tributs to	the causs of death?
Physician/M	Pa	art II. Other eignificant condition				,	en in Part I.	23b. Did	/		the causs of death?
â	- ا					,	en in Part I.	1 🗆	/	3 Prob	
2	- ا	art II. Other eignificant condition				,	en in Part I.	1 🗆	Yss 2 No an eutopsy med?	3 Prob	ably 4 ☐ Unknown re autopsy tindings ilable prior to noletion of cause
Completed by		art II. Other eignificant condition  ESS EN71				,		1 🗆 24a. Wes park	Yes 2√No an eutopsy med?  Yes 2√No	3 Prob	ebly 4 Unknown re autopsy tindings ilable prior to apletion of cause leath?
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page 2 should be Completed by	25	5. Was case reterred to medical examiner? 1   Yes   No  Manner of Death 1   Natural   S   Pending investig: 3   Suicide   4   Homicide   Homicide	Hospital: 1 lating lation of be ned 28e. Place building	npatient 2 npatient 2, hay Year) ot Injury - At horg, etc. (Specify	ER/Outpati 28b. Time Injury	ent 3 DOA Oth of 28c. Injur Wor M 1 street, tactory, office	26. Place of De ler: Nursing y at k? Yes 2 □ No	24a. Wes park  1 □  ath (Check only whome 5 □ Resi  28d. Describe  28f. Location (City or To	Yes 2 No  an eutopsy rmed?  Yes 2 No  one)  denca 6 □Oth how Injury occurr  Street and Numb wn, State)	3 Prob  24b. We ave cor of c  1 C  er (Specify ed	ably 4 Unknown re autopsy tindings ilable prior to appletion of cause leath?  Yes 2 No  Route Number.
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No Funeral Director: After this certificate has been signipletely filled in by the funeral director, page 2 should be delicely filled in by the funeral director, page 2 should be edical Certification: To Be Completed by	25	5. Was case reterred to medical examiner? 1	Hospital: 1 la	npatient 20 It Injury h, Day Year) of Injury - At ho g, etc. (Specify best of my know sis of examinat er stated.	ER/Outpati 28b. Time Injury me, tarm, s 1)	ent 3 DOA Oth of 28c. Injur Wor M 1 Doal otreet, tactory, office ath occurred at the tim nvestigation, in my o	26. Place of De Nursing y at k? Yes 2 No	24a. Wes part  1 □  ath (Check only of them of the control of the	Yes 2 No  an eutopsy med?  Yes 2 No  one)  denca 6 □Othe how Injury occurr  Street and Numb  cause(s) and ma date and place, a	3 Prob  24b. Wee ave cor of c  1 C  er (Specify ed)  er or Rura.	ably 4 Unknown re autopsy tindings ilable prior to npletion of cause leath?  I Yes 2 No  Route Number,  ated. the cause(s)

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1	, Decedent's Nam	na (First, Middla, La	ist)			ificate of		2. Date of D			3. Time of Death
an al	Benjamir	L. Abra	ms					Dec.	Dey 11.	1999	4:02 PM
	a Facility Name (	If not institution, giv	re street and number)				4b. City, Town, or L	ocation of Dea			
			tist Hospi	tal			Takoma Pa	rk	Montg	omerv	
5	. Social Security N	Number 6. S	Sex 7. Ag	o (In yrs. last		If Under 1 Year Months Days		8. Date of Bi (Month, D	rth lay, Year)	9. Birthpla Country	ce (State or Fore
-	577-48-1 Usual Residence o	128	12 M 201	98	Yrs.			Mar. 1	0,1901	New J	ersey
	Oa. State	10b. County		10c. City, To	own or Loca	ation				100	I. Inside City Lim
	MD	Prince G	enroes	Si 1	ver S	pring					1X Yes 2 1
1	0e. Street and Nu	1	corgeo	DII	VCI D	10f. Zip Code			10g. Citizen of W	hat Country	n
1	8335 12t	h Awa				2090	2		U.S.A		
1	1. Maritai Status	1140.6	12. Was Decedent Armed Forces?	ever in U,S.	13. W		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or N		- American	
	1 ☐ Never Marr 3 🛣 Widowed	ried 2 Married 4 Divorced	1 Yes 2 2 1 If Yes, Give Year or Datas:	lo		Yes 2X No		rican, etc./	1000	k, White, et White	
	/Sno	15. Decedent's Ecify only highast gra		16	6a. Decede	ent's Usual Occu	pation during most of work	ina	16b. Kind of Bu	siness/Indu	stry
-	Elementary/Seco		College (1-4or 5	+)	life. De	O NOT use retire	ed)	any .			
			3		S	alesman			Novelt		
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	P. Earle	Abrams/	Son	20b. Place	of Disposi	ition (Name of	y Rd., Si	lver Sp	ring, MD		
-	Burial 2	☐Cremation 3 ☐	Removal from Stata	cema	tery, crema	Memoria	1 01-	Dec. 14	,		
-		5 Other (Specification of Service Lication of		KING I				1999	Falls	Churc	h, VA
	1	(5. h			Dan		Goldberg   ille Pike				
	23a. Part1. Enter t	ha disaasa, or com	plications that caused one cause on each lin	the death. D							pproximate
			1	n.	1-0	0	12/001	DEMAI	EATI UDE		Prot and Death
1	mmediata Causa diseasa or condition	on	_	- W	914	C 01	VICIT	RENAL	FAILURE	~	THA
1	resulting In death)			Dua to (or as	a consequ	ence of):			21 11		
1			b					HYPERT	ENSION	<u> </u>	
1	Sequentially list co f any, leading to in cause. Enter Under	inditions, nmediate		Dua to (or as	a consequ	ence of):					
10	cause, Enter Unde Cause (Disease or hat Initiated events	injury	C	Due to (ex ex							
1	esulting in death)			Oue to (or as	a consequi	ance or):					
P			d								
P	art II. Other algni	ficant conditions of	ontributing to death be	it not resulting	in the unc	deriving causa gi	iven in Part I.	23b. Dic	I tobacco use con	tribute to t	he cause of de
1						and a second	Cattle day 4		Yes 2 No	3 Probe	1/
-	ASHD										
	NIDDM								s an autopsy formed?	avail	a autopsy findin able prior to
-	1120011									com	pletion of cause ath?
								1 🗆	Yes 2 No	10	Yes 2 No
2	5. Was case refer	red to medical					26. Place of Dea	th (Check only	ona)		
	1 Yas 2		Hospital: 1 ☐ Inpatie		Outpatient	3LI DUA			sidence 6 DOthe		
	7. Manner of Deat 1 Natural	5 Pending	28a. Data of Injui (Month, Da)	Year) 28b	o. Time of Injury	28c. Inju		28d. Describe	how injury occurr	ed	
	2 Accident	investigation 6 Could not b	000 010-0-4101	D. A15	As are		Yes 2□No	and Leastin-	(Circuit and More)	or or Break	Doudo Mumba-
2	3 Suicida	detarmined	28a. Place of Inju- building, etc		rann, stree	ы, таскоту, оптов		City or To	(Street and Number own, State)	or OF MUTAL I	JUJIS NUMBER,
2	4 Homicide			f my knowled	las desth	nonurrad at the t	ima data and stace	and due to the	caucale) and mo	Oner es et et	and .
	4 Homicide	1 Carlibina Ct	veicien. To the heat		ук, окат (	ON IB Demuse	opinion death occur	red at the time	a causa(S) and ma	ind dua to t	ou.
2		1 Certifying Ph	niner: On the best of and manner sta	axamination i	and/or inve	istigation, in my	opinion, dogin occo	Too at the three	, data and place, a		ne cause(s)
2	4 Homicide	2   Medicat Exam	ysician: To the best on niner: On the basis of and manner sta	axamination i	and/or inve		se number		29d. Data signed		ne cause(s)
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2 2 3	4 Homicide  29a. Certifier (Check only one)  29b. Signatura and	Little of certifier  rass of person who  The Day, Year,	completed causa of de	M C D	and/or inve	29c. Licen	se number 3 0921	pring			ne cause(s)
Medical Certification	4 Homicide  29a. Certifier (Check only one)  19b. Signatura and 0. Name and addr	Little of certifier  rass of person who  The Day, Year,	completed causa of de	M ( D seth (Item 23s	and/or inve	29c. Licen	se number 3 0921	pring			ne cause(s)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death Amended Item#5 perPhyG779 1/15/2000 EW 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 12:40 AM DECEMBER 30 BARLOW -REGORY 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner BALTIMORE
If Undar 24 Hrs.
Hours Min.

8. Data of Birth
Montp, Day, UNION MEMORIAL If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 5. Social Security Number **Funeral** 1**3** M 2□ F 212568191 Usual Rasidance of Decedant Months Days Yrs. Director with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Modical Examinat must be notified at 1 Yas 2 No ALTIMORE Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Funeral death Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours after 1. Operarment of Hastilh and Mental Hygiens. Important: If them 27 is marked other than "natural", or its any injury or other traumatic event, I'm Medical Earning Navar Married 2☐ Marriad 1 ☐ Yas 2 No If Yas, Give Yaar or Dates: Specify: BLACK 1□Yas 2XNo Baltimore, Maryland 21215-0020 Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) LOWSON MALL MAINTENANCE WORKER 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fether's Name (First, Middle, Last) DORO THY EWIS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. informent's Name/Reletionship (Type, Print) SUNDAY BALTO, MD 21218 SISTER 945 NORTH HILL Rd 20c. Location - City or Town, Stata 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Jana62000 LANDSDOWN, MD ZUN 21. Signatura of Junaral Servica Licensee

22. Name and Addrass of Facility

TRI-S TATE FUNERAL SERVICE

108 W. NORTH AVE BALTO MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate the disease of the complete the cause of th 21. Signatura of Funaral Service Licensee any li all Approximata Intarval Between Onsat end Deeth **Physician** Pneumonia Immediata Causa (Final disaasa or condition rasulting In daath) /Medical **Examiner** Due to (or es a consaquance of) Examiner shock DTIC Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initioted events rasulting in daath) Last Due to (or as a consequence of) 97 Division of Vital Records, P.O. Box 68760 physician Physician/Medical 176 Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown positive in Cocaeno opiate by 8 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performad? Completed 1 Yas 2 No 1 ☐ Yas 2 ☑ No confilicate 25. Was casa referred to medical axaminar?
1 ☑ Yas 2 ☐ No Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 量 27. Mannar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Altor 5 Panding invastigation 1 Naturel if or Attending after death. 1 ☐ Yas 2 Accident 3 Suicida 6 Could not be datermined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida 29a. Cartifiar 1 🗹 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as steted. Medical Tay Certifying Physician: 10 the best of my knowledge, death occurred at the time, data and place, and due to the descent due To the Ho within 24 t To the Fur completely 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licensa number Loveen Pathumana, MD

State Registrar

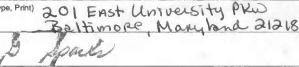
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31. Data filed (Month, Day, Year)

JAN 1 4 2000

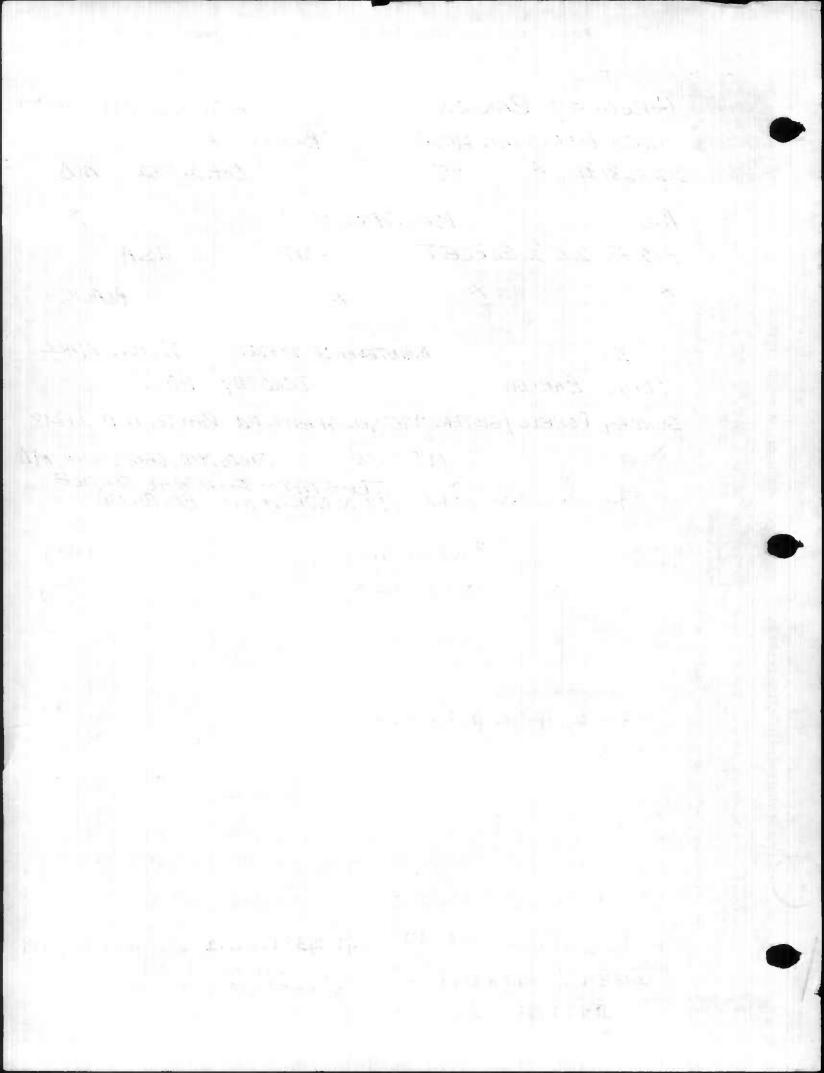
30. Neme and address of person who complated causa of death (Itam 23a) (Type, Print)

PUTHUMANA 32. Registrar's Signatura



AT 2438946 C12

DECEMBER, 30, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Q Certificate of Death Amended Item#24a perPhyG779 1/15/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1535 Hechstall Beth 31 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shoch Maryland If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) Va-5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months 1 M 2 L 246-84-877 Yrs. NORTH CAROLINA Director 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director NEWVORK UNKNOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 10550 AVENUE USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after cooperment of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural; or hen any injury or other traumatic avent, the Medical Esperiment Black, White, etc. 1X Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NURSE HOSPITAL VR5 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father'a Neme (First, Middle, Last) Be HECKSTALL KOBERT (MN-UNKNOWN) MAGGIE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 28 7+HAVE. , MT. VERNON NY 10550 YULINDA HECKSTALL (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State PETERSON CHAPEL BAPT, CHURCH OI-08-00 MERRY HILL, N.C.

22. Name and Address of Facility BROWN JR. FUNERAL HOME
JOSEPH, H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIHORE, MD. 31217 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Servich-Lique 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) physician the buria Box 68760. Bostor vehicle Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 HMKnown signed b Records. à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No Vital B 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No o 27. Manner of Death 28b. Time of 28d. Describe how injury occurred motor vehicle collision 28a. Dete of Injury (Month, Day Year) Certification: 28c. Injury at Work? 5 Pending investigation tungo 7/M 1 Netural 12/24/99 1 Yes 2 HNO 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 T Homicide US13 Ocean Huy Deloney rel 24 hours 1 Coritying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Funs completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print) Shore 32. Registrer's Signature MPH 3216 St. Florace Ten Olary AU 20832

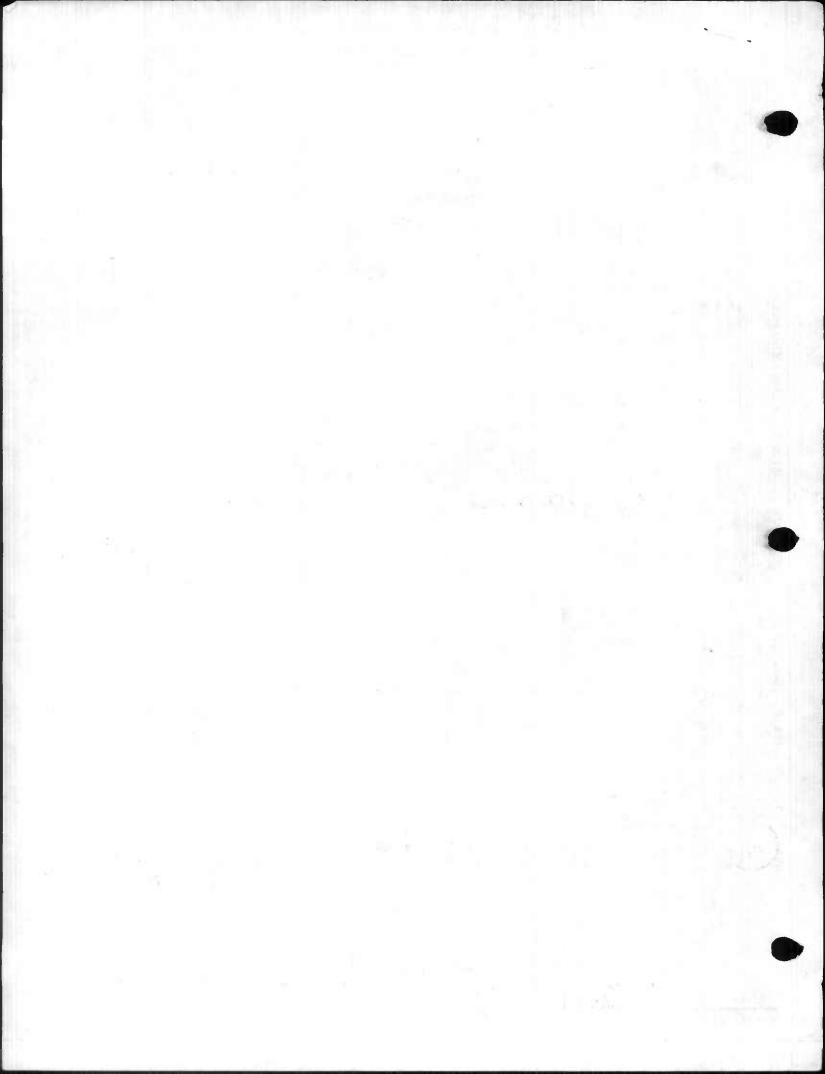
**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month) ANY 1 4 2000

Dener



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 42505 Reg. No 9 Certificate of Death Amended Item#20b perFH G779 1/18/2000 EW 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** enth C 5:25 Pm Lena M. McClintock /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Goodwill Mennonite Home **Grantsville** Garrett If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months 1□M 25kF Vre 90 Director 170-36-4003 11/22/09 PA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Somerset Confluence 1 ☐ Yas 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? i is marked other than "natural", or items 23a or marmatic event, the Medical Examinar must be n 2839 Fort Hill Road 15424 USA Funeral Permit. Pages 1 and 2 should be filed within 72 hours after dea poperature of Health and Mental Hyglene. Important: If fem 27 is marked other sery injury or other trausmythed other sery. 12. Was Decedent Ever in U.S. Armad Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, White, alc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Tressler Olive Livengood 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Dwaine McClintock 2804 Fort Hill Road, Confluence, PA 15424 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/3/2000 4 ☐ Donation 5 ☐ Other (Specify) Addison Cemetery Addison, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Humbert Funeral Home nay P. O. Box, Confluence, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Enclotage /Medical Immediate Ceuse (Final disease or condition resulting in death) ongenti Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) burial ettending physician for use as the bunk Physician/Medicai Due to (or as a consequance of): Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MSCH liscase ģ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Magner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide

1 Craifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

29c. Licanse number

mination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

the deeth certific P.O. Division of Vital Records, or Attending efter deeth. Director: Aft Hospital 24 hours e

Bnd

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29a. Certifier

(Check only one)

29b. Signature and title of certifies

Medical

cate be exec

Box 68760

within 2 To the F 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) randsuilly mo 21536 31. Dete filed (Month, Day, 32. Registrar's Signature State Registrar

2 Medicai Examiner: On the basis of exa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#25 perPhyG779 1/18/2000 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last). 2. Date of Death Month Physician OSPM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Pacility Neme (If not Institution, give street and number) Examiner oun 910 a If Under 1 Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Months Hours 1 ☐ M 2 💢 F Director 213-22-2602 75 7-24-1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director Md. Garrett 0akland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 172 Bill Roth Road 21550 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Battimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specify: p 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Made Draperies Upholstery poimit. Pages 1 and 2 ahould be file
5. Department of Health and Mental Hy,
1. In marked other
1. If then 27 is marked other
1. Items injury or other treatmetic event. 17. Fether's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be Paul Samuel Carr Iva Loretta Roth 19e. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 172 Bill Roth Rd.Oakland, Md. 21550 Paul Ridder/ son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Omega Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/27/99 Morgantown, WV. 22. Name and Address of Facility 21. Signature of Futheral Service Licens Hinkle Funeral Home P.O. Box 186 Davis, WV. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) VU Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical å Due to (or as e consequenca of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. ā 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes -2 No 12 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Affer ding 1 Neturel
2 Accident 5 Pending investigation 1 Tyes 2 No Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 8 ertifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one) To the Ho within 24 P 29b. Signature and title of certifier 29d. Date şigned (Month, Day, Year) 29c. License numbe Print) 30. Name and address of person who ed cause of deeth (Item 23a) (Type 165 32. Registrar's Signature State 8

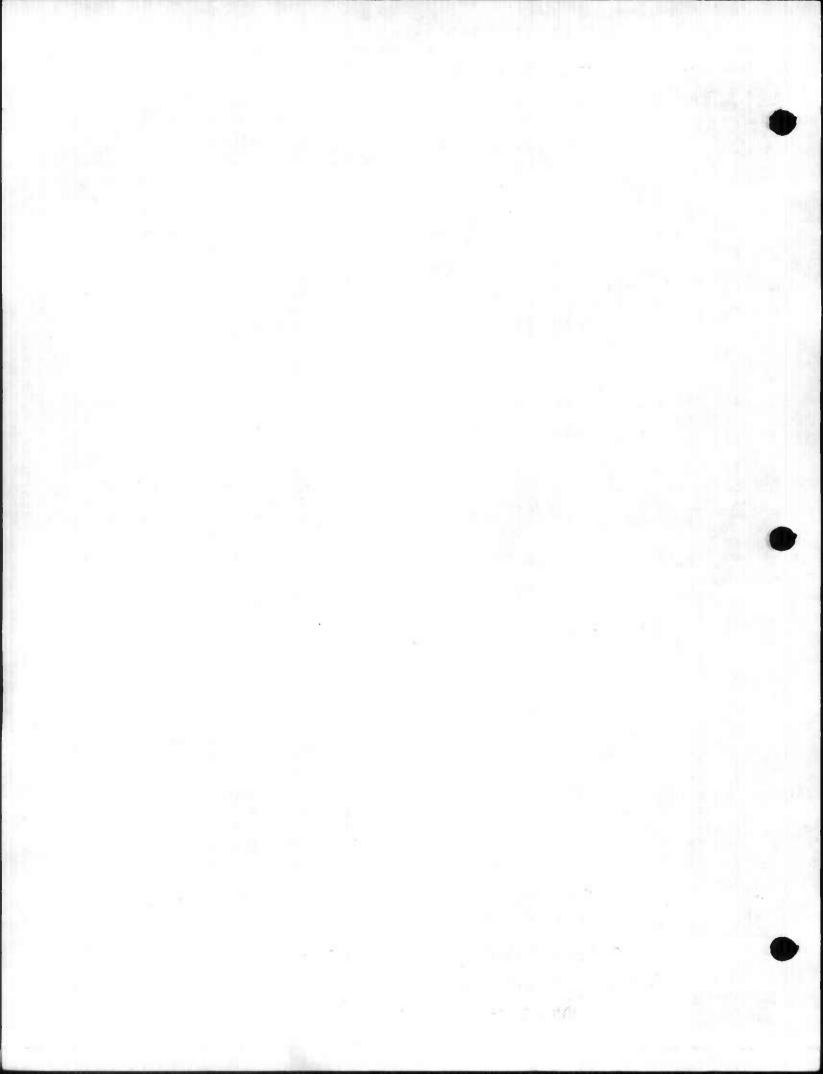
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Amende	Item#24a perPHYG779 1/15/2000 EW Certificate of Death	h	ignerieg 9 42507			
Physicia /Medic		2. Date of Dea Month DECGM	th Dey Year RER 28 1997 1:09 AN			
Examine	An English Name (Mant least) sing the street and a set of	Town, or Location of Death	4c. County of Death			
Funeral Director	5. Social Security Number  unknown  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  43 Yrs.  H Under 1 Year If Under 1 Year I	or 24 Hrs. 8. Date of Birth Min. (Month, Day Sept 4,	Year) Country)			
with the Maryland is or 28a-1 show Lhe notified at	Usuel Residence of Decedent    10a, State		10d. Inside City Limits 1 ☐ Yas 2 ☑ No			
of the negline	10e. Street and Number 10f. Zip Code		log. Citizen of What Country?			
P with		1	USA			
5-0020 72 hours after death with the Marylar naturals, or learns 23s or 28s-1 show Sisal Examinat must be notified at	11. Meritel Stetua  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Merried  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No	Origin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc. Specify: black			
121	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondery (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  roofer	ost of working	16b. Kind of Business/Industry  Construction			
d High	17. Father's Neme (First, Middle, Last)  18. Mott	her's Neme (First, Middle,				
/lan	William Jones	Willie Mae R	obinson			
	19e. Informent's Neme/Reletionship (Type, Print)  Annette Stenbach/friend  19b. Meiling Address (Street and Number 19b. Meiling Address)	ber or Rural Route Numbe	r, City or Town, State, Zip Code)			
Baltimore, semit. Pages 1 s Separtment of Hes important: if Nem any injury or othe	20e. Method of Disposition  1	Dete	20c. Location - City or Town, Stete			
Ball Permit	Baltimore, MD	21201	Baltimore Street			
Physician /Medical	23a Pert1. Enter the difeese, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart feilure. List only one cause on each line.	s cardiac or respiratory an	est, Approximete Intervel Between Onset end Deeth			
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. PNEUMDN(A  Due to (or es e consequence of):		2 DAYS			
O = = 0	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. ACQUIRED IMMONE DEFICE  Due to (or es e consequence of):  c	LIENCY SY	NDROME			
death certifi	d					
- 0 4 %	d  Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Peri		3b. Did tobacco use contributs to the cause of death?  1 Yes 2 140 3 Probably 4 Unknown			
COFC requirements		24a. Wes e				
e e de		1 🗆 Y	es 2 🖾 No 1 🗆 Yes 2 🗆 No			
Of Vital Physician: 1 this certifical rel director, p	examiner/	ce of Deeth (Check only or	ne)			
Phys of	1 Lympatient 2 LI ER/Outpatient 3 LI DOA 4 LI M	28d. Describe h	ence 6 Other (Specify) ow injury occurred			
Division Complete National Processing Proces	3 Suicide 4 Homlcide  6 Could not be determined  28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specily)	28f. Location (S City or Tow	treet and Number or Rural Routa Number, n, State)			
the Hospi in 24 hou the Funer pletely fill	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date of the composition on the composition of the certifier of	end place, and due to the c eeth occurred at the time, o	ause(s) and manner as stated. late and place, end due to the cause(s)			
To t			29d. Dete signed (Month, Day, Year)			
	Annuad ha Bodden HD Asayyıl 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	6 14 A34 1	DECEMBER 28 1999			
State	9-BODDETI 6381C SMITHY SQUARE C. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature	LEH BUR	NIE HD 21061			
Registra	JAN 1 4 2000 Benever B spar	ila	1000			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#23a perPhyG779 1/15/2000 EW 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day **Physician** 5:30pm December 30, 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Hospital Baltimore Sinai If Under 24 Hrs. 8. Dete of Birth
Hours | Min. (Month, Day, Year) 6. Sex 104M 20 F H I Inder 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 218-62-9923 December 20, 1956 Director Usuel Residence of Decedent 10b. County 10a. Stete 10c, City, Town or Location 10d. Inside City Limits - would 1 Yes 2 No Funeral Director Hokes, Lev 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates: 2 No frican 8 1 Yes 2 No Specify Completed by 3 Widowed 4 Divorced american 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Hygiene. condery (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with the page of the pag Baltimore, Maryland 17. Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be .Ora 20 19a Unforment's Neme/Reletionship (Type, Print) sister 19b. Meiling Address (Street end Number or Rural Route Number) City or Town, State, Zip Code) LVIA OK MD 2/2/2 20b. Plece of Disposition (Name of cametery, crametery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremation 3 Pemoval from State Department Pages Important: Pages any Injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lies 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** stem Organ Falure from overwhelming infection Immediate Cause (Finel disease or condition resulting in death) /Medical 1-545 tem Orya Examiner Physician/Medical Examiner **SEPSIS** The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): HIV physician the burial Box 68760. Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed page 1 Yes No 1 Yas Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours etter deat To the Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier RES medical resident 30,1990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINdi Hospital Baltmore

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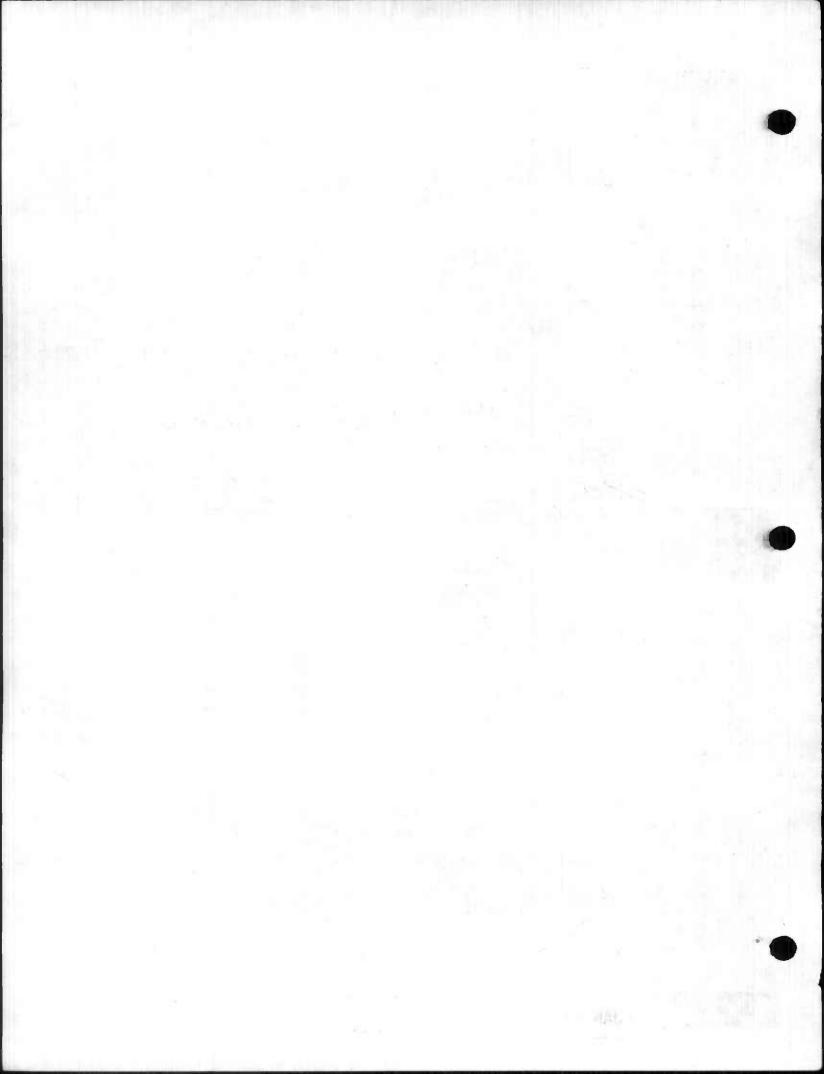
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31. Dete filed (Month, Day, Year)

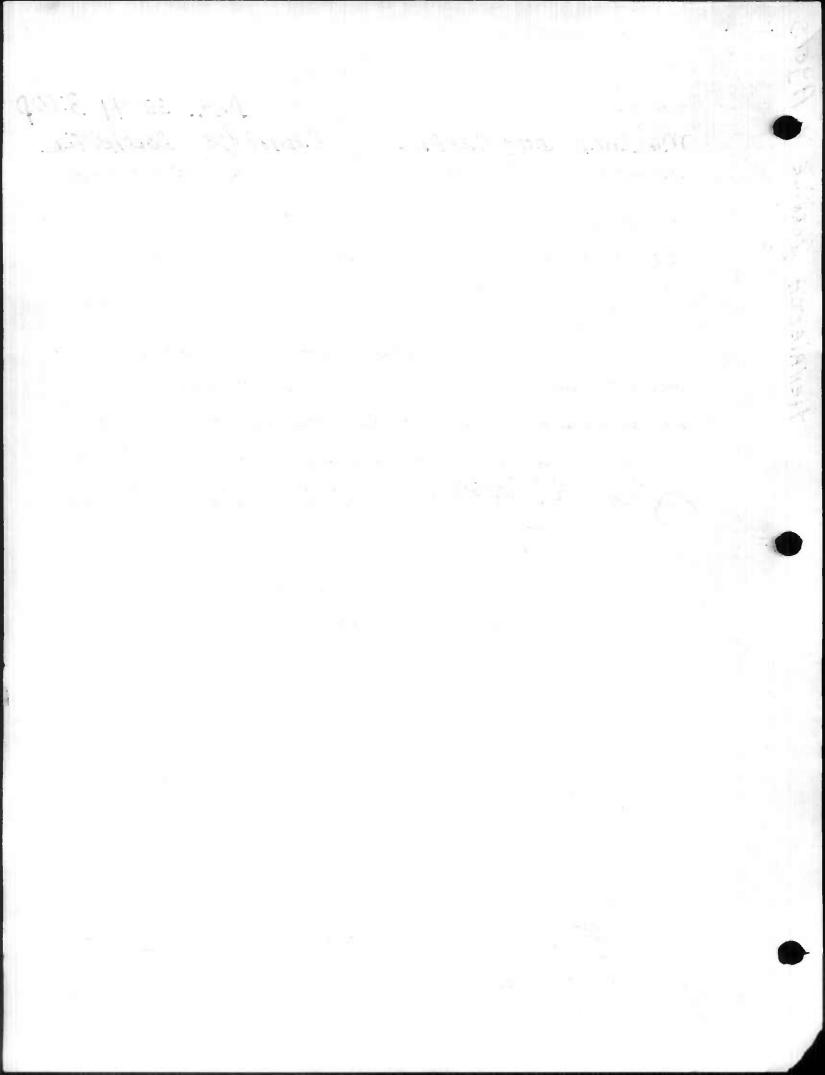
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32. Registrar's Signeture



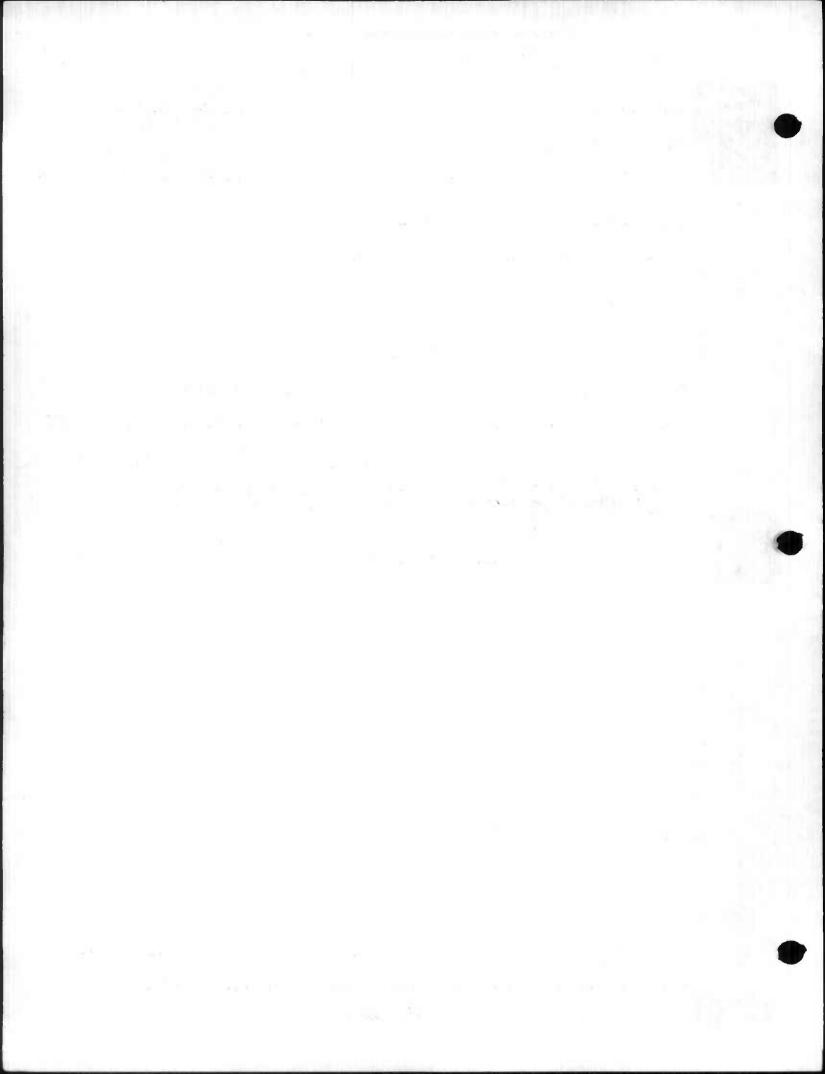
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physiclan** Henrietta Bernice Ayers /Medicai 4a. Facility Name (If not institution, give street and number) 4b. Gity, Town, or Location of Death 4c. County of f Examiner CARI If Under 1 Year 5. Social Security Number **Funeral** 1□M 2XF Months Days Maryland Yrs. 10,1928 135-24-0358 Director 71 Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland Dorchester East New Market 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code b USA Nerrs 23a 21631 5933 Heritage Road Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Reservation Clerk Commercial Airline marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Mary Thamer Higgins John William Ayers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 豊 6677 Palmers Mill Road, Hurlock, MD 21643 Important: If Item 27 any Injury or other to Nancy Smith/Friend altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete B 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1/4/00 Cambridge, Maryland 5 Other (Specify) Cambridge Crematory 22. Name and Address of Fecility
Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 11. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner erebro vascular Accordent physician and the buriel-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the attending p use P.O. Part II. Other algrificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 2 1 No 3 Probably 4 ☐ Unknown 1 ☐ Yes signed be del Records, þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy peen completion of cause of death? The law page 2 s 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 70 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation **■** Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital ...
within 24 hours effer
To the Funeral Dir. 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D50987 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Aurora Stier mo 21613. AHMED 300 NAWAZ 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State 2000 JAN 0 Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 425 10

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Physician / Medical Examiner  The physic		ortme ortani				Woo				2000	wad	swort	n, Uni	.0
Physician / Medical Examiner  The physic	g	Dape Impo		AA AAAAA AAAAA	200	_				s Funera	1 Ho	me, I	nc.	
Physician (Madcial Examiner    Macing		_		23a Part Enter the disease or complete	lications that caused	the death	500	Unive	rsity Bl	vd.,W, S	ilve	r Spr		
Note   Part II. Other significant conditions   Part II. Other significant   Part II. Oth		Physician		shock, or heert feilure. List only o	ne cause on each lin	16.	. Do not enter	1110 111000 01 0	ying, soon as card	ac or respiretory a	irrest,		inter	val Between
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24b. Were eutopsy finding evaluable prior to completion of cause of death of the cause o	9	atten for us	lan											
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25. Wes case referred to medical examinar?  1	ecords	law requires as been sign 2 should be	pleted by									ppsy	complet	prior to ion of cause
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tille of pertilier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Nemg-and notices of person who completed cause of deeth (Item 23a) (Type, Print)  Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855		The ata h	Con							10	Yes 2	™ No	1 ☐ Yes	2□ No
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tille of pertilier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Nemg-and notices of person who completed cause of deeth (Item 23a) (Type, Print)  Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855		clan: ertific ector,		examinar?						eath (Check only	one)		Cas	sev Hous
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tille of pertilier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Nemg-and notices of person who completed cause of deeth (Item 23a) (Type, Print)  Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855	5	hysic his c		TLI THE ZLAND	1 LI inpatie		ER/Outpatient	3LI DOA	4 LI HUISING	Home 5□ Res	Idence	6 Other		
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tille of pertilier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Nemg-and notices of person who completed cause of deeth (Item 23a) (Type, Print)  Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855	2	tend leath tor: A	cat	E C. Moordon										
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Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855		8		30. Neme and redress of person who co	ompleted cause of ric	eth (Itark	23a) (Type Pri		020		ресе	ember	29, 19	999
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State State  State  AN 0.8 2000		Sta	te	31. Date filed (Month, Dey, Year)	32. Pegistre						- C 4 V J	,		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene qq Certificate of Death Amend #7, 1/03/2000, BMW, Montg. Co. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month Vaar Physician Karen Moore Boone December 28, 1999 2059 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery if Under 24 Hrs. 8. Data of Birth All Month Day, 1949 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Hours Months North Carolina 10M 20F 50 -49 246-84-4333 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 'natural', or tlems 23a or 28a-f show 1 Yas 2 No Maryland Montgomery Director Silver Spring 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 1022C First Street 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ÛNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, atc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) sher 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black altimore, Maryland 21215-0020 À 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Computer Analyst Cosmos, Inc. 17, Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumama) Be pemil. Pages 1 and 2 should be Department of Health and Mental Important: If New 27 is marked of Winston Moore, Jr. Effie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winston Moore, Jr. Father 6 Turnmore Court, Silver Spring, MD 20906 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 8 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/00 Rockville, MD Parklawn Memorial Park 22. Nama and Address of Facility
McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, 200 D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Pontine Bleeding 8 days Examiner Due to (or as a consequence of) Examiner Malignant Hypertension years attending physician and for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of): 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aspiration pneumonia signed to þ The law requires should I 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yas 2 ♥ No 1 ☐ Yas 2 ☐ No Mospital or Attanding Physician:
 124 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director. Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as ststed. Medical

Box 68760, 0 ۵. Division of Vitai Records,

> State Registrar

31. Date tiled (Month, Day, Year) JAN 03 2000

notela

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certified



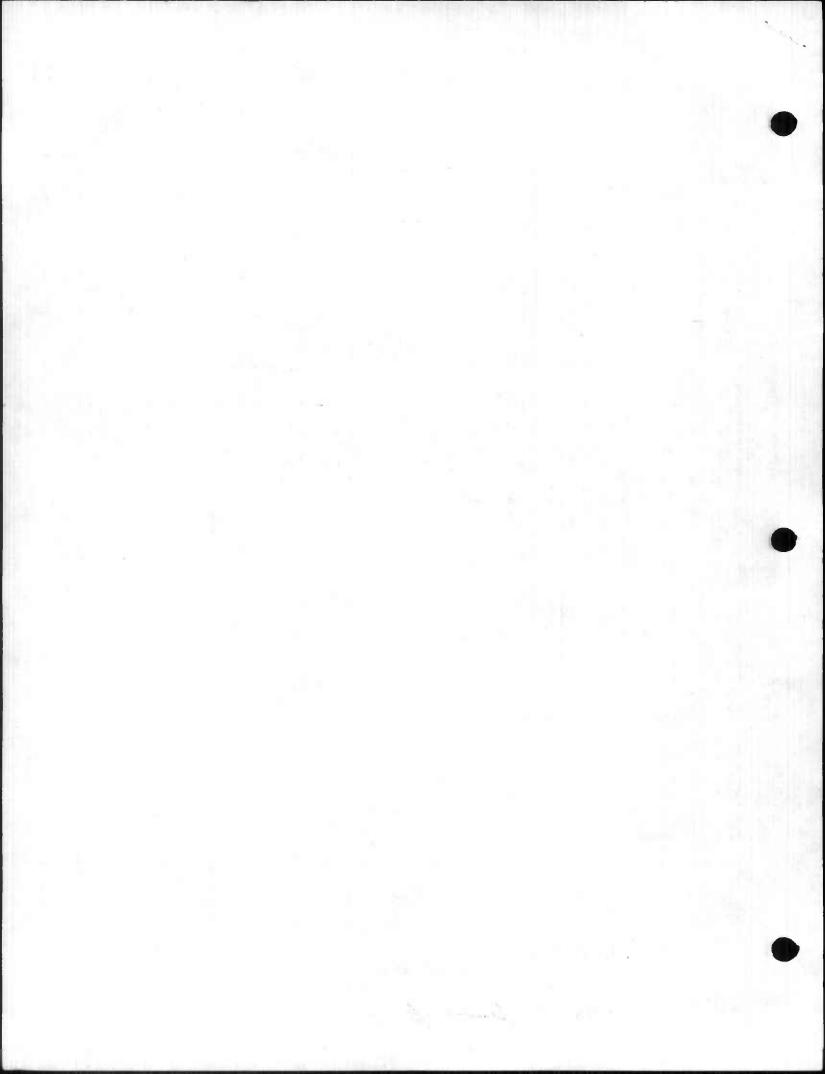
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29c. License number

D 19971

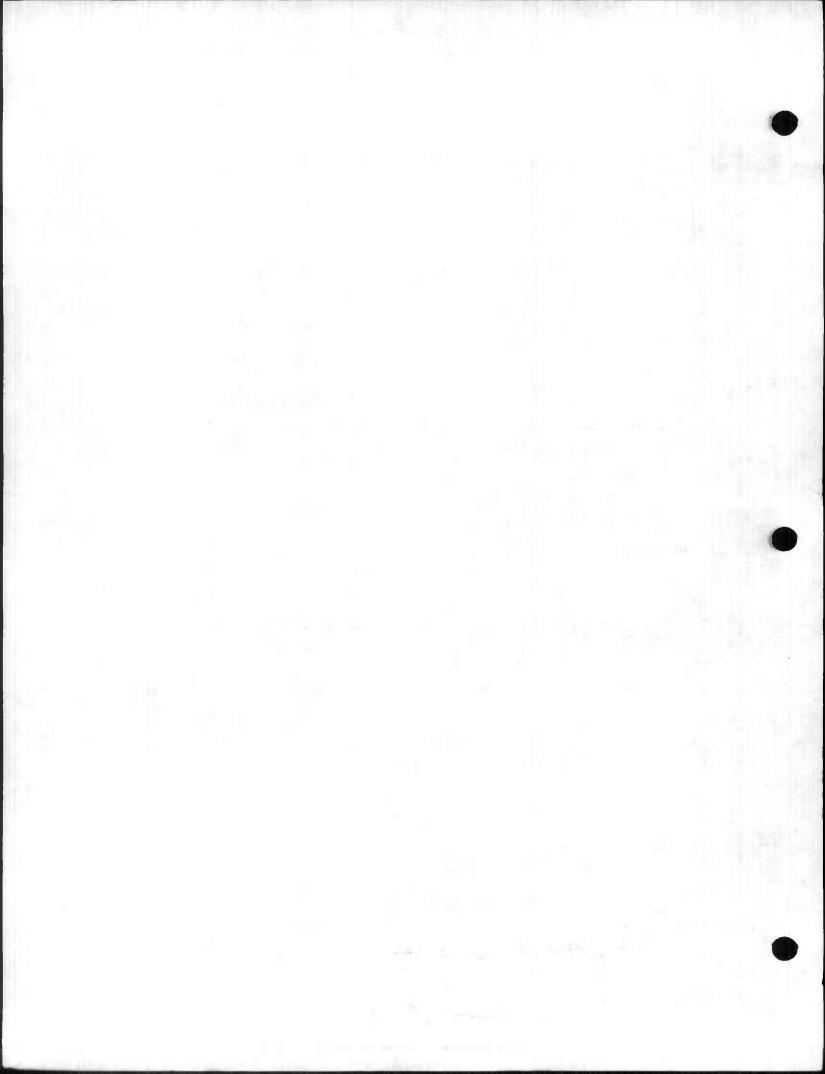
29d. Data signed (Month, Day, Year)

December 29, 1999

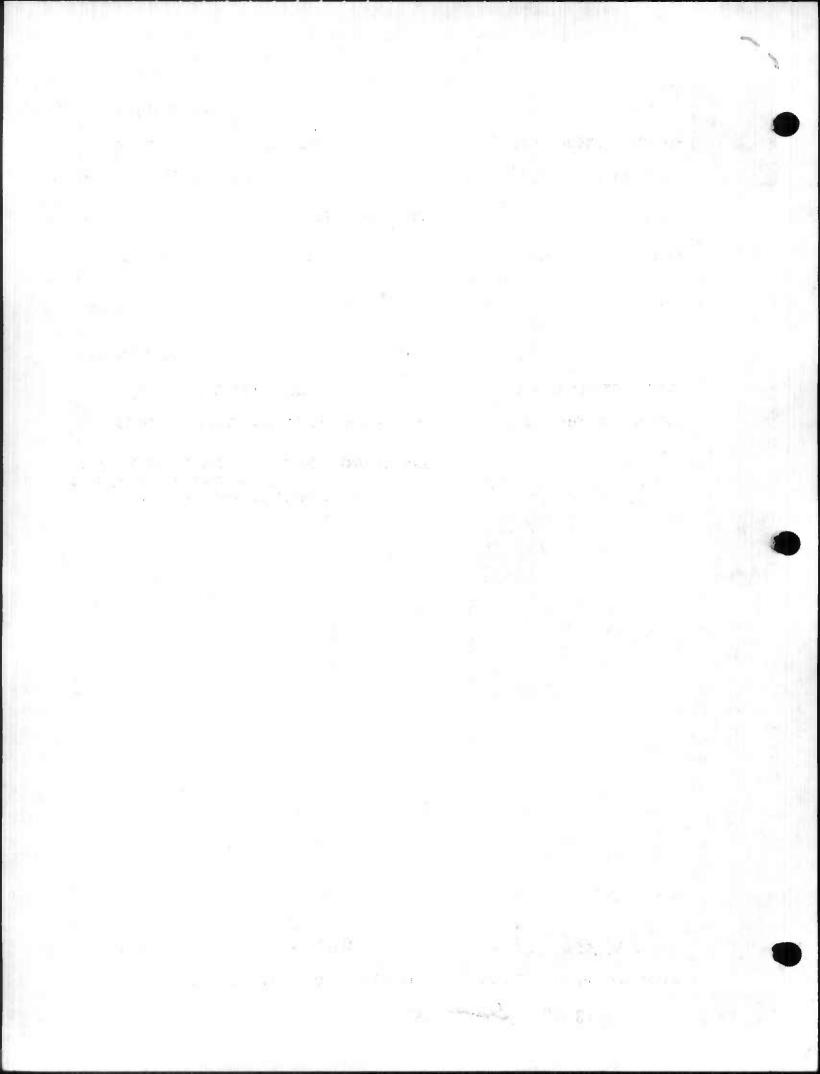


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dev Year **Physician** December 29, 1999 9:27 am <u>Barbara Ann Bickel</u> /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Suburban Hospital Bethesda If Under 24 Hrs. Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Funeral 1 M 2 F Months Days Hours Min. 48 Yrs. June 23, Director VIrginia 216-58-9045 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylar Department of Health and Mentai Hygians. Important: If Item 27 is marked other than "natural", or Nama 23s or 28s-f show applying or other traumetic avent, the Medical Emminer must be notified above. 1 Yes 2 No Director Maryland Montgomery Rockville 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Ivy League Lane USA Funeral 20850 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Clerical Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Charles D. Bickel Mary Matassa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Denfield Ave., Kensington, MD Charles D. Bickel/ Father 20895 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan 3 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Gate of Heaven Cemetery 2000 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the ral Service Picenser 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. amo 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each light. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac Arrest 3 hrs Examiner Due to (or es a consequence of): Physician/Medical Examine Seizure 3 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 24 hrs Seizure Disorder , failure to take medicine Due to (or es e consequence of): Birth Defect 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicat axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 X Yes 2 ☐ No 1 Inpatient 2 NER/Outpatient 3 DOA ž 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. tnjury at Work? 5 Pending investigation 1 X Naturat 1 Yes 2 No 2 ☐ Accident after death Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the F å 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Dey, Year) D 50275 December 29, 1999 5 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print) 11125 Rockville Pike, Rockville, MD MD20852 Eric Greenberg, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2000 souls Registrar



DHMH 16 Ray 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death DECEMBER 29.1999 **Physician** ELLA BRYAN 3:10 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner **BROOKEVILLE** MONTGOMERY 1610 GOLD MINE ROAD If Under 1 Yaer | If Under 24 Hrs. 5. Social Security Number Birthpiace (Stata or Foraign Country) 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 TF Months Yrs. 577 16 6852 Director JUNE 11,1917 MARYLAND Usual Residence of Deceden the Maryland 10a Stata 10b. County 10c. City, Town or Location "natural", or flams 23a or 28a-f ahow edical Examiner must be notified at 10d. Inside City Limits MD. MONTGOMERY Director SILVER SPRING 1 Yas 2. No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20905 806 SNIDER LANE UNITED STATES death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. WHITE permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or then any injury or other treumatic avant, the Medical Event 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) **JAMES** HERBERT **JOHNSON** SR. CARRIE **EDWARDS** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) H. ARDELL HOWES, DAUGHTER 1610 GOLD MINE ROAD, BROOKEVILLE, MD. 20833 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removal from State BURTONSVILLE UNION CEM. 4 □ Donation 5 □ Other (Specify) 1/4/00 BURTONSVILLE, MD. 21. Signature of Funerat Service Licensee 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME uri P.O. BOX 5038, LAYTONSVILLE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Finat disease or condition resulting in death) /Medical Non Smarc Examiner Examiner Vein physician and the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): attending p for usa as P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ves 2 No 3 Probably 4 Unknown Division of Vital Records. Š 24b. Ware autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy page 2 s 1 □ Yes 2 No 1 Yas or Attanding Physician; B 25. Was casa refarred to medical 26. Placa of Death (Check only ona) DAUGHTER'S Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this HOME 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Affer Natural 5 Pending investigation n 24 hours after death. • Funeral Director: After the function of the functin 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. To the Mosp within 24 ho To the Fune completely fi er: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. Licansa number 29b. Signeture and title 29d. Data signed (Month, Day, Year) MO D35635 12 DECEMBER 30,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

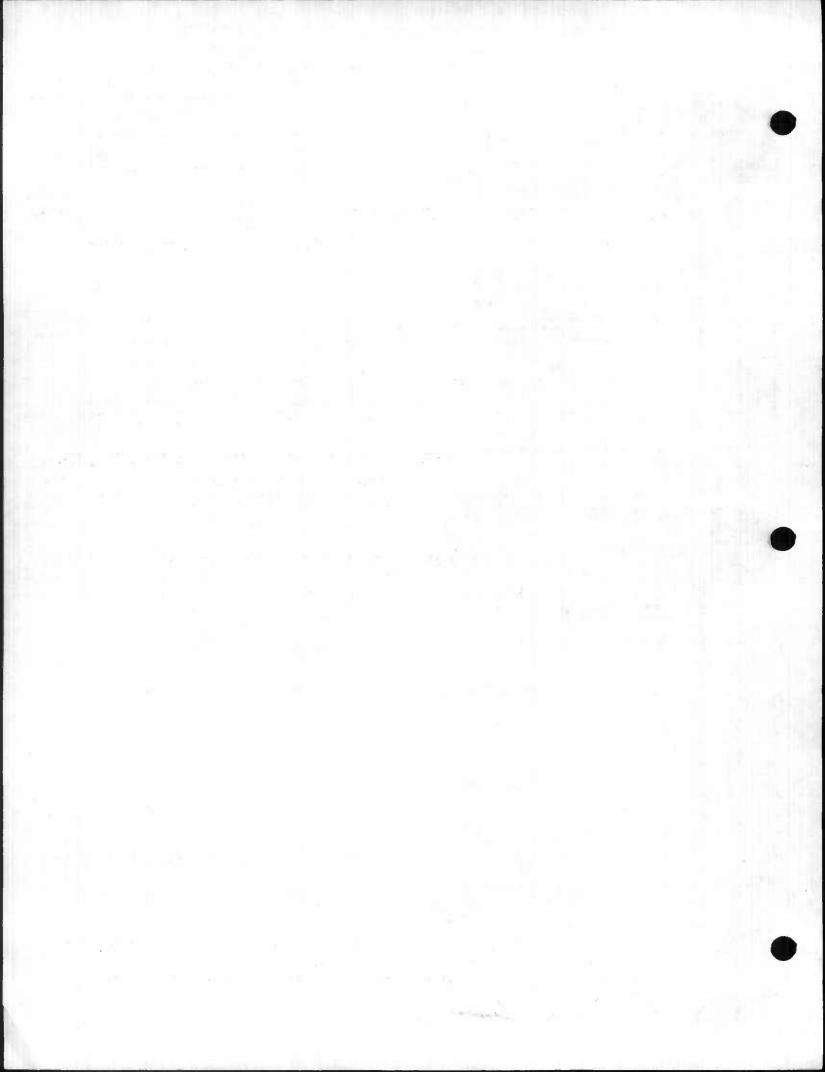
State

31. Data filed (Month, Day, Year)

JAN 0 3 2000

JOSEPH KAPLAN, M.D., 18111 PRINCE PHILIP DR. SUITE 327, OLNEY, MD. 20832

32. Bogistrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3074 Month Rebecca Coblenz Dec 4b, City, Town, or Location of Daath 4a Facility Name (If not Institution, give streat end number) 4c. County of Deeth Hebrew Home of Greater Washington Rockville Montgomery If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociei Security Number 6. Sax 7. Age (In yrs. last birthday) 1□M 2\ F Deys Yrs. 042-07-5973 February 6, 1916 New York Usuet Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 6121 Montrose Road 20852 United States 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - Amaricen Indian, Bleck, White, etc. Wes Dacedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Merried 2 ☐ Married 1 Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Mary Freedhand Benjamin Tauber 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Raletionship (Type, Print) 8005 Treasure Tree Court, Springfield, VA 22153 Son Robert Coblenz 20b. Plece of Disposition (Nema of cemetary, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Deta 1 ABuriel 2 Cremetion 3 Removel from Slate 4 ☐ Donetion 5 ☐ Othar (Specify) 1/3/00 Pinelawn, NY Wellwood Cemetery 21. Signature duneral Service Licensee 22. Nama and Addrass of Fecility Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA Doold Party Enter the disease, of complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory errest, and the disease of complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory errest, and the disease of complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory errest, and the disease of complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory errest, and the disease of complications that caused the death. Approximata Interval Between Onsat and Death Immediate Causa (Final disaase or condition resulting in death) Coronary Due to (or es e consequence of): UNO Supsis Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably ▲ thiknown 24b. Wara autopsy findings aveitable prior to 24a. Was en eutopsy performed? completion of cause of death?

**Physician** /Medical Examiner

Examine

Physician/Medical

p

Completed

Be

2

Certification:

edical

certificate

2

Funeral D Hospital

To the Hor within 24 h To the Fur completely

**Physician** 

/Medical

Examiner

Directo

Funeral

by

**Funeral** 

Director

7 is marked other than "natural", or thems 23s or 28s-f show traumatic event, the Med cal Examine, must be notified at

al Hygiene.

permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic even

Baltimore,

the Maryland

death

72 hours after

Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated evants resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

ALZheimer's

32. Registrer's Signature

Pernicious 25. Wes cesa referred to medicel axeminer? 1 Yes 2 No 1 Inpatient 2 ER/Outpatiant 3 DOA

28e. Dete of Injury (Month, Dey Year) 27. Mannar of Death Neturel 5 Pending invastigation 2 Accident

JAN 06 2000

6 Could not be datarmined 3 ☐ Suicide 4 Homicida

31. Date filed (Month, Day, Year)

. Novo Zaine

1 ☐ Yas 2 ☐ No

26. Piece of Deeth (Check only one) Other: Nursing Homa 5 Residence 8 Other (Specify)

28d. Describe how Injury occurred

28b. Time of 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

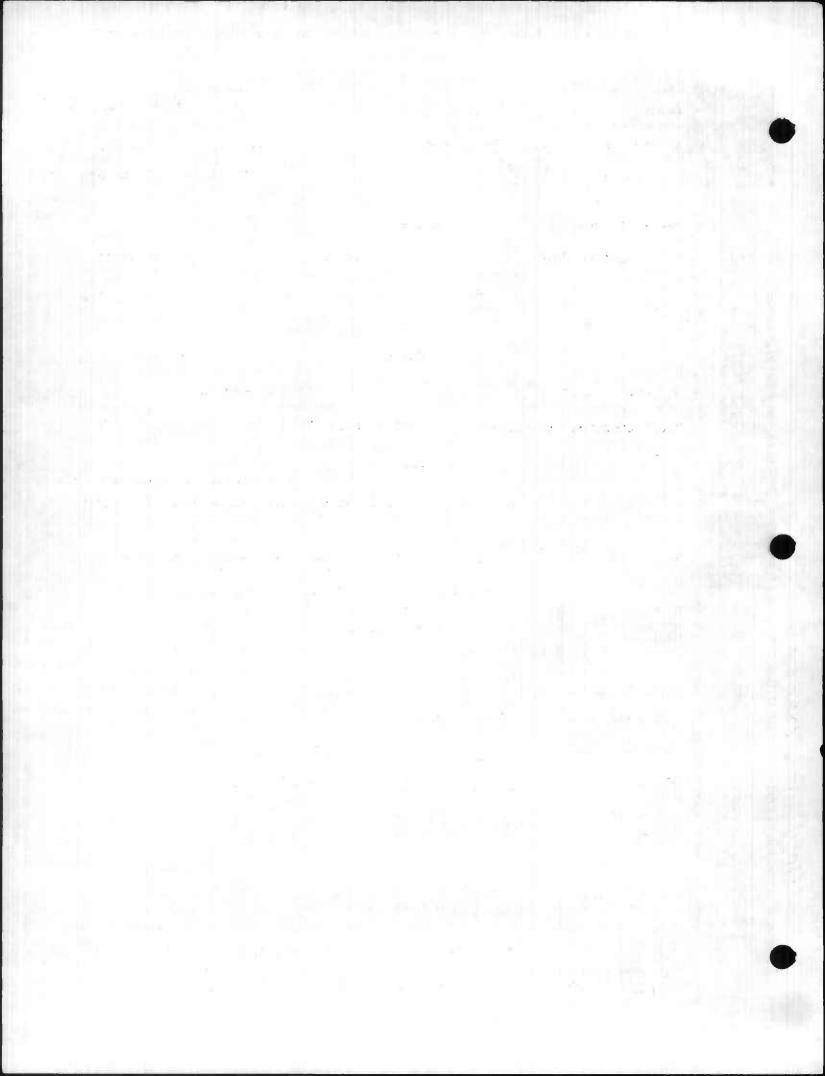
Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licansa number 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifiar

Lanseule 30. Nama and eddress of person who completed ceuse of deeth (Itam 23e) (Type, Print) CONSUE Lo

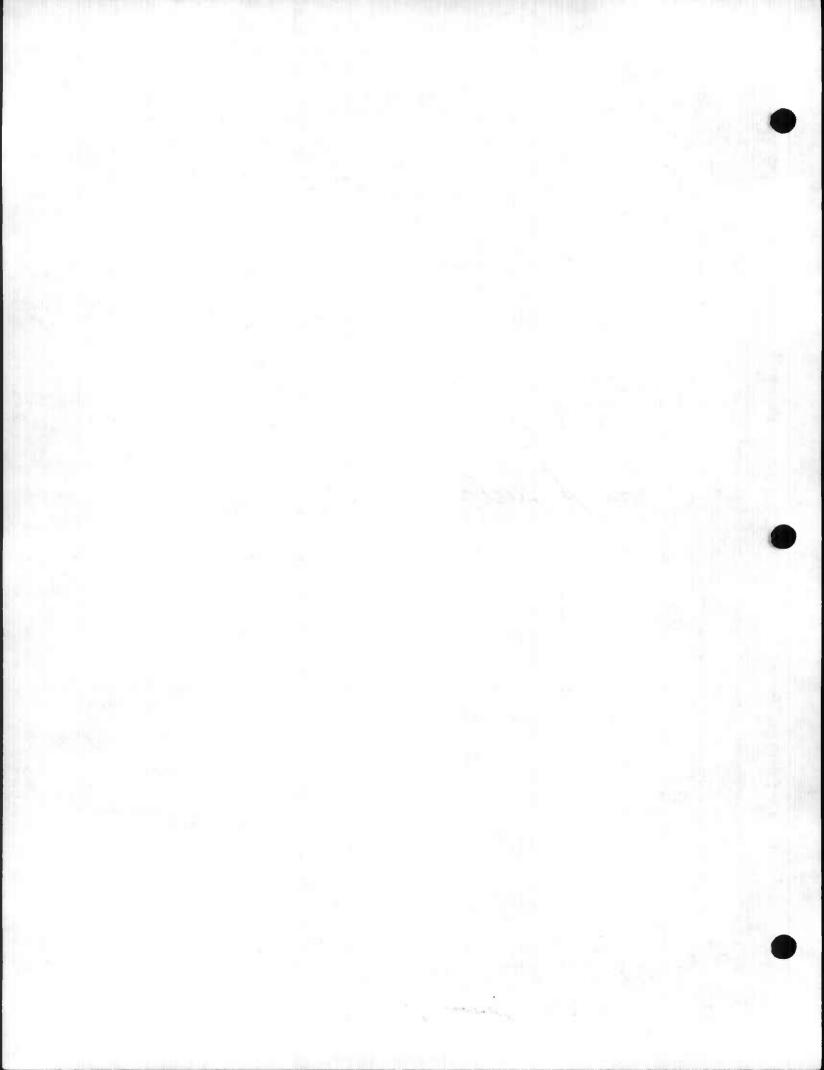
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 99 425 16

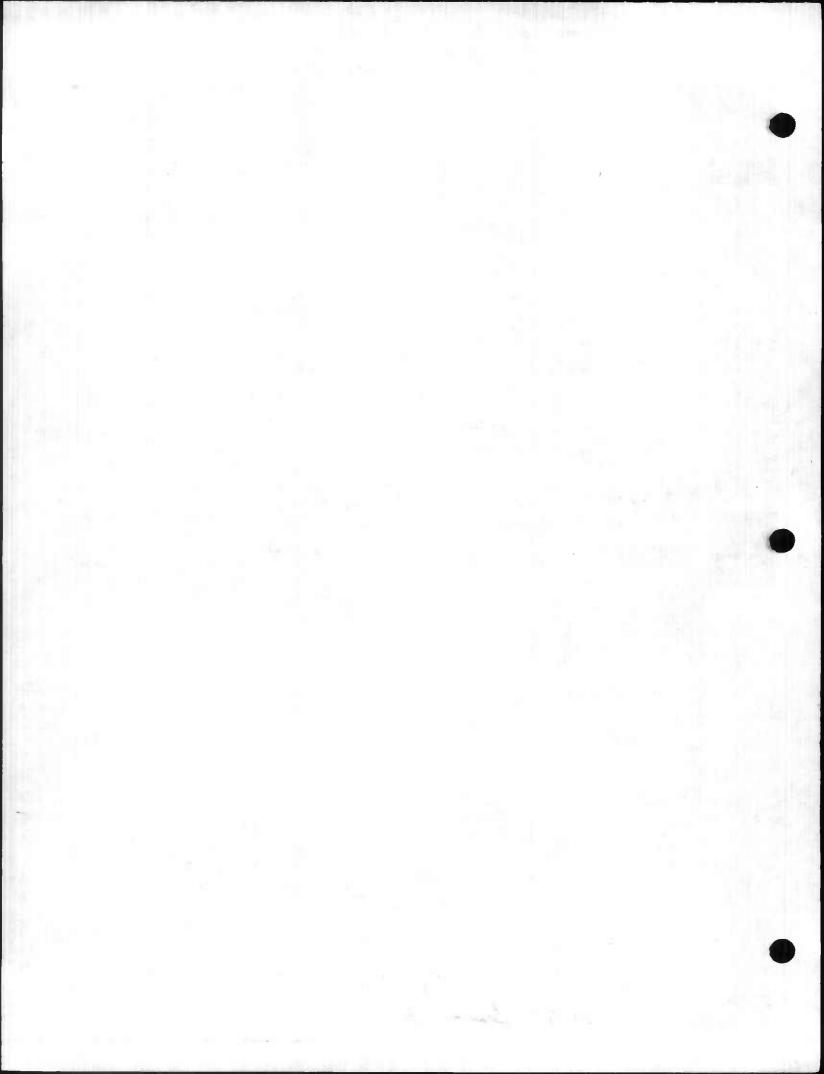
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	Physician /Medical	Esther H. Clem						December	0.4		2:07	am
	Examiner	4e Facility Neme (If not institution, give s	treet end number)				4b. City, Town, or	Location of Death	4c. County of	of Deeth		
4		Forest Glen Skill					Silver S		Montgo	mery		
	Funeral	5. Social Security Number 6. Sax	M 2NE	n yrs. last birtho	Months	r 1 Yaar Deys		(Month, Day,	Year)	9. Birthpla Country	ice (State o	or Foreign
	Director	139-16-2907		81 Yrs				Oct 23,	1918	Tenne	ssee	
	B 8	Usuel Residence of Decedent  10a. Steta 10b. County	10	c. City, Town o	r Location					100	d. Inside Ci	ity Limits
	dany respondent	Manual and Mantagers		T 4-4	.11-						1 🗆 Yas	
	or 28a-fr be notified Directo	Maryland Montgome:	L y	Hyattsv		o Code		10	g. Citizen of W	het Countr	v?	
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	ther death in the them a 23 alone must. Funeral	6715 Munsey Street	2. Was Decedent Eva	r in U,S.	3. Wes Dece	784 dent of I	Hispanic Origin? (S	Specify Yas or No-	U . S . A .	- Americer	n Indien,	
0		1 ☐ Never Merried 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				an, Mexican, Puar	to Rican, atc.)	Black	k, White, et	C.	
020	Er.,	3 X Widowed 4 □ Divorced	If Yes, Give Year or Detes:		1 ☐ Yes	2 🔼 No	Specify:		Specify:	Whi	te	
Maryland 21215-0020	ed within 72 hours after ygiens. we then "natural", or the t, the Medical Examina Completed by Fu	15. Decedent's Educ		16a. De	cedent's Usu	el Occu	pation	1	6b. Kind of Bus			
2	within 7 than 'r the Med	(Specify only highast greda Elementery/Secondery (0-12)	College (1-4or 5+)	lit	e. DO NOT L	ise retire	during most of wo	rking				
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yla	Monta Monta arked afte er	Ira Patrick Hayes					Margar	et Oheith				
lar	2 sh and is m	19e. Informent's Neme/Reletionship (Typ	e, Print)	19b. M	eiling Addres	s (Street	tend Number or R	ural Route Number,	City or Town, S	Stete, Zip C	Code)	
	and a 27 a tr	W. Allen Clem, III					Street, 1	Hyattsvil		2078		
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Baltimore,	amit. Pe apartman mportant my injury nos.	21. Signature of Funeral Service Licentee	. / /				collins	Funeral	Home T	nc		
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	/Medical Examiner	Immediate Ceuse (Finel disaese or condition resulting In deeth)	Metast	atic	Colo	n	Carcin	oma		i I	yea	15
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	certificate be executed rightly physician and use as the burial-transit n/Medical Examin	Sequentially list conditions, if any, leeding to immediate	Due	to (or es e con	sequence of)	:				į		
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ta	certificate rector, pag	25. Wes case referred to medical					26. Place of De	eth (Check only one			-/-	217
>	Physician: r this certificant and director, rT O Be (	examinar?	ospitel:	2 □ ER/Outpa	itient 3 D	OA OI	han	Home 5 ☐ Reside		r (Specify)		
	g Phys er this seral di	27. Menner of Deeth	28e. Dete of fnjury (Month, Dey Ye			28c. fnju Wo		28d. Describe ho				
ō	Attending is redeeth.  Cotor: After by the funer  Ification	1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, Day Ye	ear) inju	M		Yes 2□No					
	after deet olfrector: Jin by the	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of injury - building, etc. (S	At home, ferm	street, fector	y, office		28f. Location (Str City or Town		er or Rural	Routa Num	ber,
	tal or Attending P rs after deeth. al Director: After t led in by the funers Certification:	4 - Homodo	building, etc. (3	pecity)				Only or Town	Diele/			
	he Hospit in 24 hour he Funera pletely fill edical	29e. Certifier 12 Certifying Physi (Check only 2 Medical Examin	clan; To the best of mor: On the basis of exa	y knowledge, d	eth occurred	et the ti	me, date end place	e, end due to the ca	usa(s) end mer	nner es sta	ited.	,
	To the Hospital or Attending Phywithin 24 hours after death or To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	one)	end menner steted					uned et the time, da	te eno piece, s	no oue to t	ne cause(s	"
	To within	29b. Signeture and title of certifier		1	29	c. Licen:	se number	29	d. Date signed	(Month, D	ey, Year)	200
	5	Much Reve	n- (ol	rent	1. D.	D	33159	1	recem	per:	21,1	117
		30 Neme and address of person who com	npleted ceuse of deeth	(Item 23e) (Ty	pe, Print)		. 1	11/02 (	1		20	2910
		Kuth Kevess-Ce	onen M.L	). 8'10	o be	orgi	a AVE \$	1 E 1400 Si	iver of	mng	MI	2
	State	31. Dete filed (Month, Dey, Year)	32. Registrer's	Signature 4	do	21				)		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 30, 1999 3:32 PM December Henrietta A. Cannella /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year H Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F Director 87 Aug. 2, 1912 Maryland 076-18-3682 Usual Residence of Decedent the Maryland 10a. Stete 10b, County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 □ No Director 28a-f Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Nerna 23a USA #415 20016 Funeral 4201 Butterworth Place, NW 14. Race - American Indian, 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. a filed within 72 hours after ut Hygiene. other than "natural", or fler 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ♣ Divorced Yeer or Detes: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Switchboard Operator Insurance permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg important: If Item 27 is merked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) a 2 Charles H. Maddox Esther Lusby 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) 1131 University Blvd., W. Penthouse #1 20902 Allen H. Cannon (nephew) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Jan.3, 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 2000 Brentwood, Maryland 22. Name end Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert1. There the disease, or completions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) RRHYTHMIA /Medical Examiner Examiner The law requires that the death certificate be executed Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): physician s the burie Box 68760, Physician/Medical Due to (or es a consequence of): 98 use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 TYes 2 TNo Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No death. Investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 18 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. edical 29e. Certifier completely (Check only To the vithin 2 one) 29c. License number 29d. Date signed (Month, Day, Year) DCT 80, 1999

WWW FIRO #401 Reversion

100852 29b. Signature end/title of-ceftifier len 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JAN 0 3 2000 Registrar



**Physician** 

/Medical

Examiner

1 Decedent's Name (First Middle Last)

4a Facility Name (If not institution, give street and number)

DANITZA I.

CAMPOS

## Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death	

2. Dete of Deeth Month

4b. City. Town, or Location of Deeth

DECEMBER

25 1999

4c. County of Death

MEXICO

3 Time of Death

3:25 A

10d. Inside City Limits 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No

9. Birthplace (Stete or Foreign

MEXICO

14. Rece - American Indian, Black, White, etc.

Specify: HISPANIC

HIGHLAND RD. & CLARKSVILLE CLARKSVILLE HOWARD If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, JAN 23, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1□M 2KX Yrs. JAN. 1972 27 **Director** 518-25-4787 Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location Directo MARYLAND PRINCE GEORGES LAUREL 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ntal Hygiene. d other than "natural", or frame 23a or event, on Medical Examples must be 20708 Funeral 11611 CLOCK TOWER LANE 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Stetus filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: MEXICAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) RETAIL ELECTRONICS ADMINISTRATIVE ASSISTANT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be filt Department of Heelth and Mental by Important: if item 27 is marked oth any injury or other traumatic avam and. Be ADLY CASTREJON 2 JOSE CAMPOS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ADLY E. CAMPOS/MOTHER 11611 CLOCK TOWER LANE LAUREL, MD 20708 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/30/99 BELTSVILLE, MD CHESAPEAKE CREMATORY 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility
HINES-RINALDI FUNERAL HOME, INC. + nus bucks. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Physician /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner Due to (or as e consequence of) Physician/Medical Examiner certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): physician s the burial 68760 that initieted events resulting in death) Last Due to (or as e consequence of): attending Box USB The law requires that the death P.0. Pert ff. Other afgniffcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contributs to the cause of death? 94 1 Yes 2 No 3 Probably 4 Unknown 6 signed b Records, þ Be Completed 24a. Was en autopsy pege 1 Nes 2 No Division of Vital To the Hospital or Attending Physician; 25. Wes case referred to medice! 26. Place of Death (Check only one) examiner? To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1♥ Yes 2□ No this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred edical Certification: After 1 Naturel 2 Accident 5 Pending Investigation ours after deeth. lersf Director: Aft filled in by the fur 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the fime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E **DECEMBER 25, 1999** 30. Name end address of person who completed ceuse of death (flem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street and Number City or Town, Stete) High

Clarksville Musy and

State

3 Suicide

29e. Certifier (Check only one)

4 Homicide

31. Dete filed (Month, Dey, Year) JAN 0 3 2000

29b. Signature end title of certifier

6 ☐ Could not be

32. Registrar's Signeture

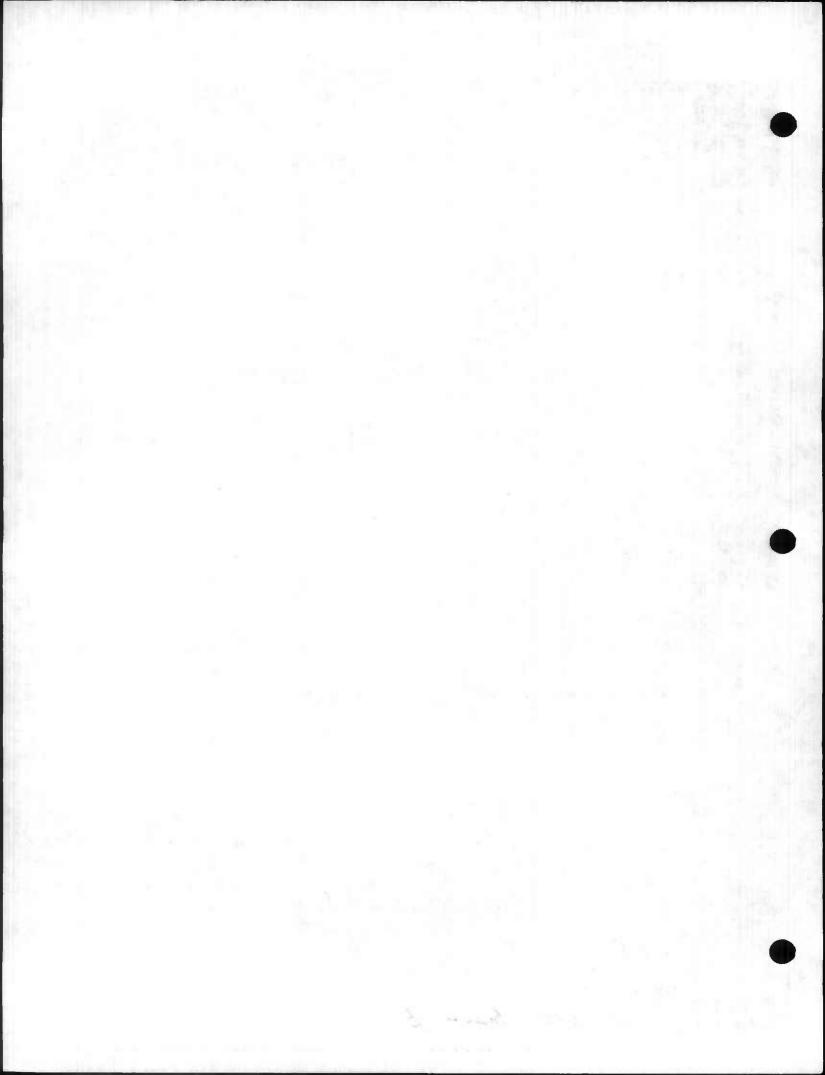
(n)

1 Yes

within 24 hours To the Funeral Completely filled

0

Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Dewey B. Crawford 29, 1999 December 4:07 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 9720 Woodland Drive | SIIVEI SPIENT | STATE | STAT Montgomery 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1MM 2□ F 91 Yrs. Director 439-09-8158 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b Norms 23a 20910 USA 9720 Woodland Drive Funeral 12. Wes Decedent Ever in U,S. Agmed Forcas? 1 M Yes 2 □ No If Yes, Give 1942 Yeer or Detes: 1945 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. filed within 72 hours after 1 Never Merried 2 Married 1942-1945 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 General Trucking Truck Driver altimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is married other any injury or other traumatic event 005s. 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Silas Crawford Julie Gray 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfra T. Crawford/ Wife 9720 Woodland Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/3/00 Parklawn Memorial Park Rockville, MD 21. Signature of Funeral Service Licensee 22. Nama end Address of Facility Francis J. Collins Funeral Home, Inc. Ken 500 University Blvd., W, Silver Spring, MD 20901 23a (1). Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit cooles The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760. that initiated events resulting in death) Last Due to (or es e consequence of): for use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 25. Was care interred to medical examiner 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physicien: 8 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) \$ 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier Hickords wel 5+1 0-12-703 12-30-99 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

**DHMH 16 Ray 6/95** 

State

Registrar

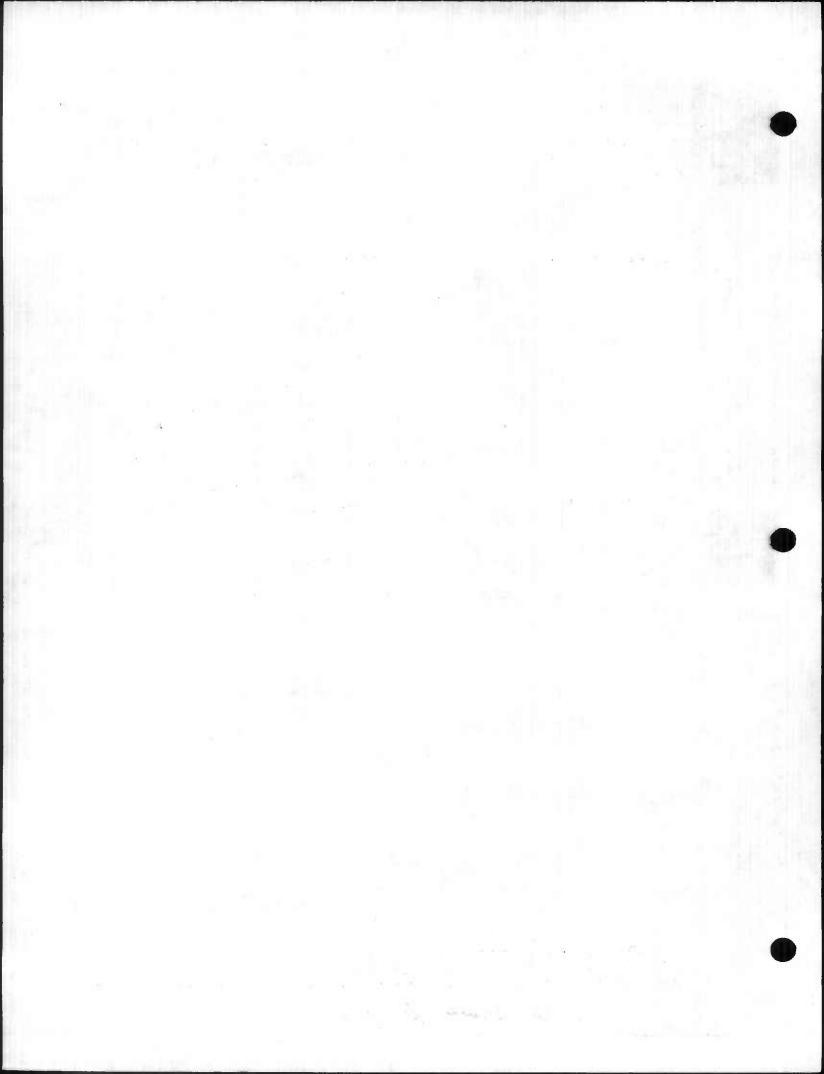
Edward J. Richards, M.D.

JAN 03 2000

31. Data filed (Month, Day, Year)

32. Registrer's Signatura

10301 Georgia Ave., #203, Silver Spring, MD 20902



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Data of Deeth 3. Tima of Death **Physician EDNA** COOPER 12 21 99 1728 /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 24 Hrs. Birthplace (Steta or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M SCXF Months Days Hours Min Director 66 Usual Rasidence of Dacedani 10e. Siele 10b. County 10c. City. Town or Location 28a-1 show 10d. Insida City Limits the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Ocomol 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whal Country? 23a or 1973 2/85 13. Was Decedant of Hispanic Origin? (Specify Yas or Noff Yas, specify Cuban, Maxican, Puarto Rican, atc.) Colona oad 12. Wes Decedant Evar in U,S.
Armed Forces?
1 ☐ Yas 2 ☐ No
If Yes, Giva or items 11. Marital Status 14. Rece - American Indian. Bleck, Whita, atc. Pages 1 end 2 should be filed within 72 hours after nent of Health end Mentel Hygiene. Int: If item 27 ia marked other then "natural", or ite 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Black Yaar or Datas Completed 15. Decedant's Education (Specify only highest greda complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) 8th grade Collega (1-4or 5+) 17. Fathar's Namy (First, Middla, Last) Ne - WOrker YO ultr other traumatic event. 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Reynold Brittingham Kichard Reynol (
19a. Informant's Name/Ralationship Type, Print) 70 Nellia 19b. Mailing Addrass (Street end Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Department of Health e important: If item 27 is any Injury or other tra-Pocomoke (hysband) 1913 (colona 20b. Place of Disposition (Name of comatary, cramatory or other pleca) md, 2185, DOPOT ICd. 20a. Method of Disposition Data 20c. Location - City or Town, Slate 1 Burlel 2 □ Cramation 3 □ Ramoval from Stata St. James 4 ☐ Donetion 5 ☐ Othar (Spacify) 12-26-99 Pocomoke City, md. 22. Nama and Addrass of Facility 21, Signelura of Funaral Service L Bennie funeral Smith Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. City md. Approximate Intarval Between Onsat and Death Physician Immediate Ceuse (Final disaasa or condition resulting In death) /Medical HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Examiner** Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed the buriel-tran Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or injury Due to (or as a consaquance of): physicien Physician/Medicai that initiated avants resulting in death) Lest Due to (or as a consequence of): Part ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? iis certificate has been signed by director, page 2 should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performad? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical axaminar? 26. Pleca of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2 No 70 the funeral 27. Mannar of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how injury occurred

P.O. Box 68760, Division of Vital Records,

After this certificate has Attending Physician: To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Medical

JOHN T. BULKELEY, M.D. 31. Dete filed (Month, Day, Year) State

DEC 2 9 1999

29b. Signeture end title of certifier

5 Panding invastigation

6 Could not be

n 56 Sullsely

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

1 Neturel 2 Accidant

3 ☐ Sulcida

29a. Cartifiar

4 Homicide



28a. Place of Injury - At homa, farm, straal, factory, offica building, etc. (Specify)

m.g.

106 MILFORD STREET

1 Certifying Physician: To the basi of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mennar as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) and mennar stated.

29c. License number

D0003599

1 Yes 2 No

SALISBURY, MARYLAND 21804

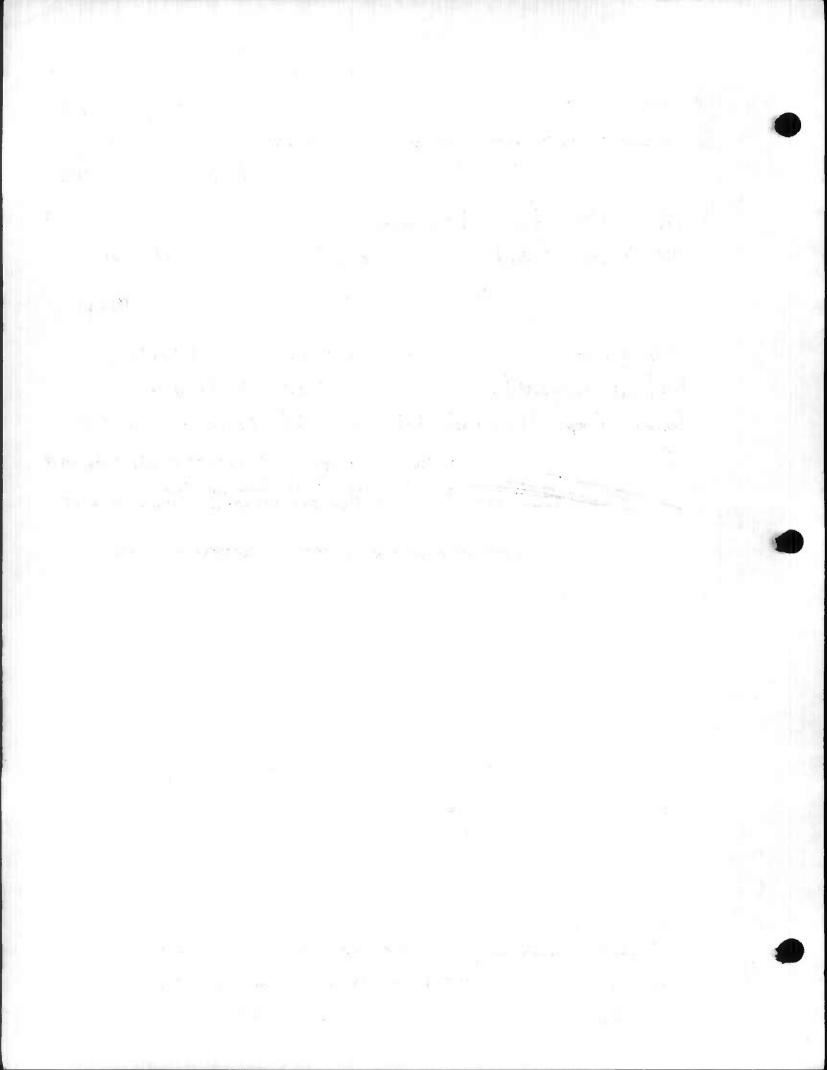
28f. Location (Straat and Number or Rural Route Numbar, City or Town, Stata)

12-22-99

29d. Date signed (Month, Dey, Year)

**DHMH 16 Bey 6/95** 

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** Inez Dabney December 26, 1999 3:30 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Fox Chase Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Months Yrs 577-01-6362 94 June 15, 1905 Mississippi **Director** Usuei Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show the Maryte r than "natural", or items 23s or 25s-f sho the Medical Examiner must be notified at XX Yas 2 No Directo D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ij 4727 Eads Street, N.E. 20019 United States Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Bieck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status hours after ☐ Yes 2 A No f Yas, Giva 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiana. Elamantary/Secondary (0-12) Collega (1-4or 5+) Clerk Pentagon Uth and Mental Hygis 27 is marked other: r traumetic event, II 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) ae Pages 1 and 2 should be Ambrose Shief Rebecca Salvand 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health Important: If Nem 27 William G. Dansie conservator 601 Indiana Ave. N.W., #814, Washington, D.C. 20004 altimore. 20b. Placa of Disposition (Nama of 20a. Metbod of Disposition Date 20c. Location - City or Town, Stata camatary, cramatory or other place) ŏ 1 Buriei 2 Crametion 3 Ramoval from Stata 12/30/99 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 21. Signature of Funeral Service Licensee 22 Nama and Address of Facility
McGuire Funeral Service, Inc. Compson 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not aniar the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervai Between Onsat and Deeth **Physician** /Medical Immediate Cause (Final Cardiopulmonary Arrest disaasa or condition rasulting in daath) Examiner Due to (or as a consequenca of): Examiner 72 hrs. Aspiration Pneumonia the death certificate be executed burial-trar Sequentially list conditions, if any, leading to immediata ceusa. Entar Undarlying Cause (Disease or injury that Initiated events rasulting in death) Lest Dua to (or as a consequanca of): and P.O. Box 68760. attending physician Physician/Medical the Dua to (or as a consaguanca of): use as for ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown law requires that þ Records, 24b. Ware autopsy findings evallable prior to completion of cause of death? 24e. Was an autopsy Completed peed page 2 1 Yes 2 No 1 Yas 2 No certificate Division of Vital 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only ona) Other: W☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yas 2 XXIII this funeral 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: After 1 Naturai 5 Pending investigation Injury al or Attending s after death. 2 No 1 Yes 2 Accident 6 Could not be 3 Sulcide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, daie and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a, Cartifian (Check only one) 29b. Signatura and Mary bentiller 29c. Licansa number 29d. Date signed (Month, Day, Year) D52261 December 26, 1999

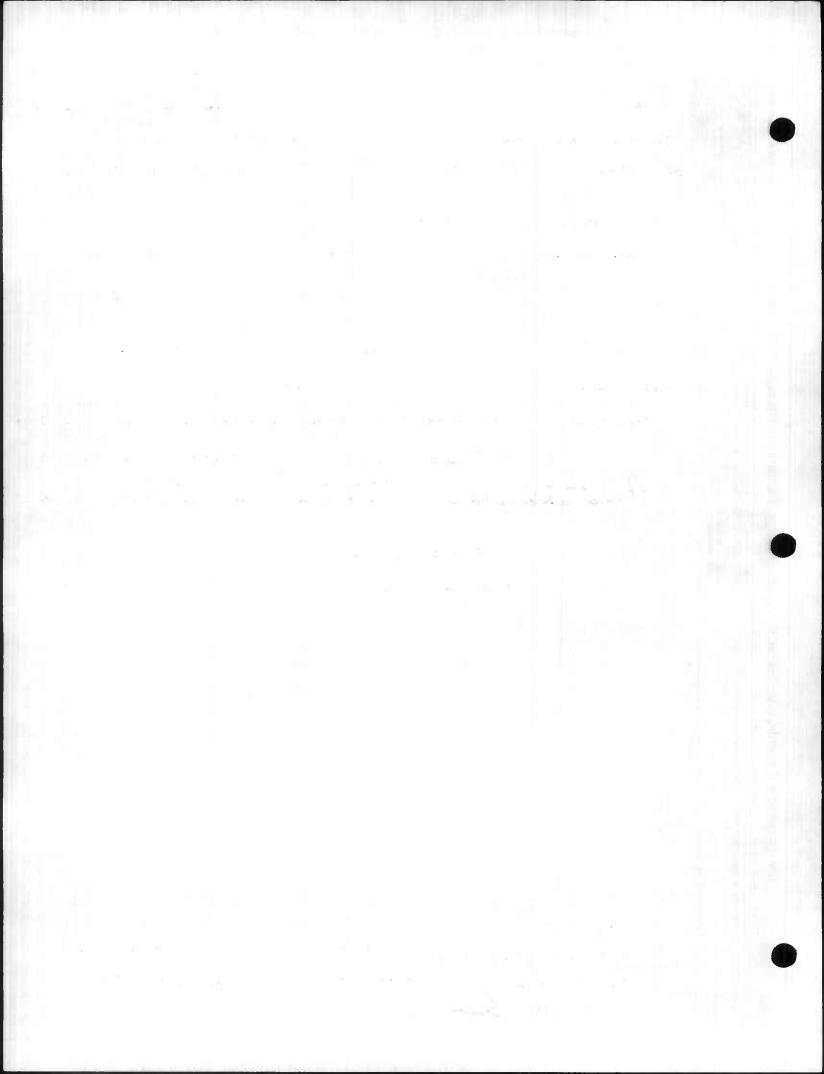
State Registrar 31. Data filad (Month, Day, Yaar) JAN 0 3 2000

30. Nama and addrass of person who complated cause of

1299 Lamberton Drive, Silver Spring, MD Alan R. Segal, M.D. 32. Registrar's Signatura

eath (Item 23a) (Type, Print)

souls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Ann Mumford Dickinson 27, 1999 6:00 PM Dec. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Carriage Hill If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 86 Yrs Director 043-38-6801 Nov. 23, 1913 New Jersey Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or Nems 23a or 28a-f ahov The Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4906 Jamestown Rd. 20816 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status filed within 72 hours after Hygiene. Wher than "naturel", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygid Important: If Itam 27 is marked other i any Injury or other traumatic avent, an 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 8 Harriet Oliver Norman Winthrop Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4906 Jamestown Rd. Bethesda, MD 20816 Lucinda D. Conger/Daughter Baltimore. 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ID Cremation 3 ☐ Removal from Stata Dec. 31,99 Alex., VA 4 Donation 5 Other (Specify) Metropolitan Crematory 22. Nama and Address of Facility De Vol Funeral Home 2222 Wisconsin Ave 21. Signature of Funeral Service Licensee N.W. Washington, D.C. 20007 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Pneumonia Examiner Due to (or as a consequence of) Examiner Stroke physician and the burial-transit be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Aspiration Physician/Medicai Due to (or as a consequence of): . attanding USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

page 2 director

been signed by the a should be detached Completed cartificata Physician: å P this After this funeral o Certification: Attending ne Hospital or Attanding in 24 hours after death. he Funeral Director: Afte pletaly filled in by the fun.

Division of Vitai

within 2 10

Medical

25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 Pending 1 X Natural investigation 2 Accident

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

D0004179

the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and transfer in the state. 29c. License number 29d. Data signed (Month, Day, Year)

26. Place of Death (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

December 30,1999

1 Yas 2 No

ted cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

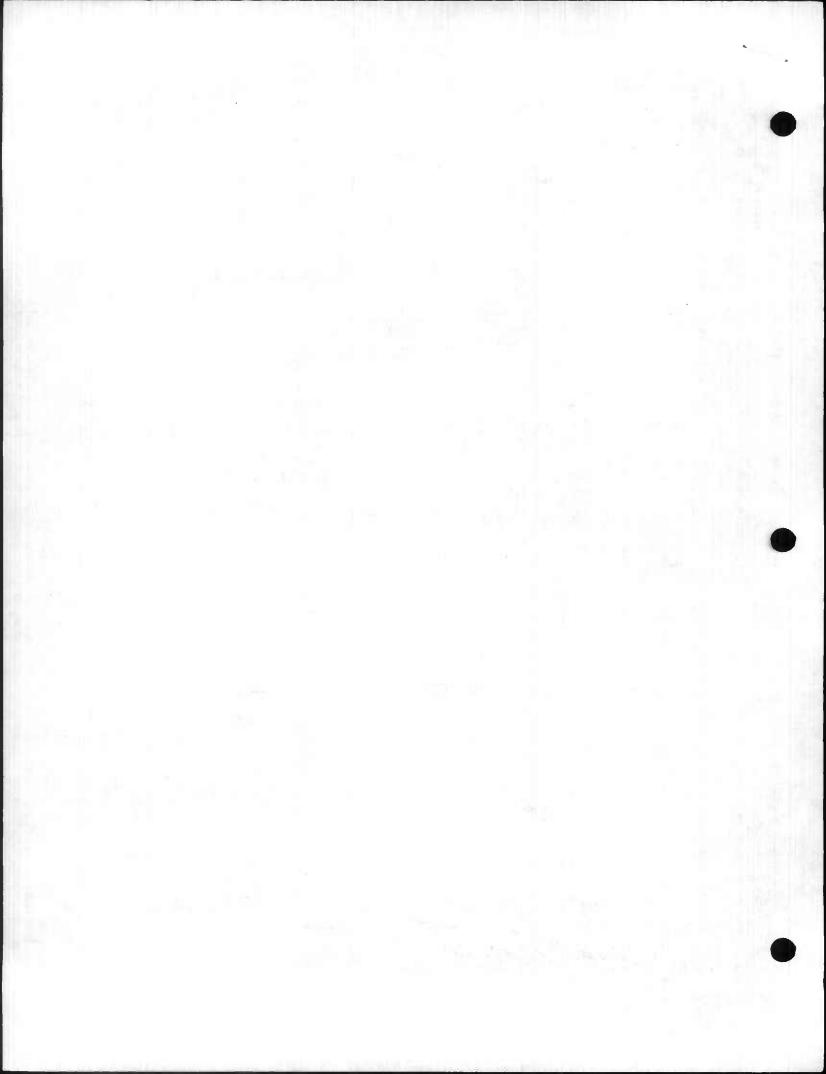
4 ☐ Homicide

(Check only one)

29b. Signature and title of portifier

James J. Foster, 5530 Wisconsin Ave., Chevy Chase, Md. 20815

State Registrar 31. Data filed (Month, Day, Year) 32. Registrar's Signature JAN 05 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death /3/2000, BMW, Montg. Co 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1999 3. Time of Death Day Physician Nicholas - ouis December 26 1996 09:46 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Adventist Hospital GYOVE Rockville Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 5 Months Hours Min. NA Director 1999 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Gaithersburg 1 Yes 2 No Directo Maryland Montgomery 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? "natural", or hams 23a or 20882 United States 6413 Sweet Meadow Court death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. Ther then "netural", or he 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health end Mentel Hygiene Important: If Item 27 ie marked other the eny Injury or other treumatic event, training NA NA 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Jenkins Louis Dyer Tracev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 Sweet Meadow Court, Gaithersburg, Md. 20882 Dyer / Father Louis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Gate of Heaven Cemetery 12/30/99 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Ulmonan Examiner Examiner Retardation 4wwth attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) 100 Physician/Medical resulting in de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes 1 Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinae: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA

30. Name and address of person who com

4-3225

December.

led cause of death (Item 23a) (Type, Print) NIGAM MD Shady grove

MD 20850 Rockville Hospital Adventist

State Registrar

03 2000

31. Date filed (Month, Day, Year)

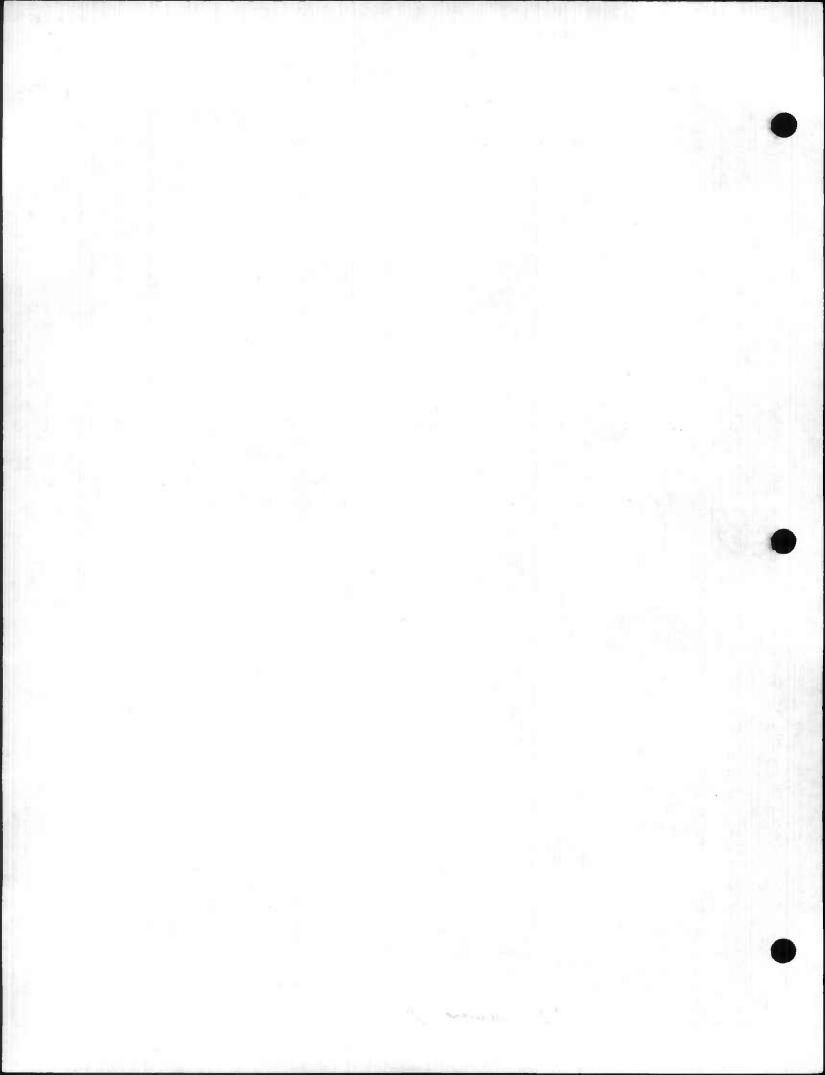
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State of Maryland / Department of Health and Mental Hygiene

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)	J	->	<u></u>	U	60	Ope

					Ce	rtificat	te of	Death		F	Reg. No.		1 ( 0 6.4	
Ob	1. Decedent's	Nama (First, Middle, L							2	. Data of Dea		Yaar	3. Tima of Deeth	
Physician /Medical			Agne	ury				Decemb	er 29,	1999	3:30 PM			
Examiner	4a Facility Na	ama (If not institution, g	ive street and nu	mber)				4b. City, Town	, or Loca	tion of Death	4c. Count	y of Death		
	Poton	nac Valley	Nursing	Home				Rockvi	11e		Mont	tgome	rv	
neral	5. Social Secu	urity Number 6.	Sex	7. Aga (In yrs.	last birthday)	If Unde Months	r 1 Yaar Days	If Undar 24 Hours	Hrs. 8	Date of Birth	th	9. Birtho	laca (State or Foreign	
ctor	084-05	5-1329	1□M 2⊠F	90	Yrs.	MURITIS	Days	riours			3, 1909	New	York	
	Usual Resider	nce of Decedent		140- 00										
iner must be notified at		10b. County		TOC. CIT	y, Town or Lo								0d. Inside City Limits 1 ☐ Yas 2 ☒ No	
Directo	Maryla		omery		Beth								287 1.11	
F	10e. Street an					10f. Zij	p Code				10g. Citizan of			
Ti I		Montgomery	_				208				United			
Funeral	11. Marital Sta		Armed Fo		,S. 13.	Was Dece If Yas, spe	edent of Fecify Cub	lispanic Origin an, Mexican, P	17 (Specification Richards)	ty Yas or No- can, atc.)		ce - Amario ick, Whita,		
by F		Married 2 Married	If Yes, Gi	/8		1 ☐ Yas	2 🔯 No	Specify:			Specia	fy: TTL		
			Year or D	atas.	16a Dass	dontin Llou	ual Oamum	ation.			10h Vind of E	Wh:		
ete		15. Decedent's (Specify only highest g			16a. Dece (Give	kind of wo	ork done	during most of d)	working t		16b. Kind of E	usinessin	bustry	
Completed	Elementary 1.2	/Secondary (0-12)	College (1	1-4or 5+)		erwri		,			Insur	canco		
	17. Fathar's N	lama (First, Middle, Las	st)		Julia	- L W L L		18. Mother's	Nama (f	First, Middle.	Meiden Sumai			
To Be	John	Edward Feu	ry							McGone				
-		nt's Name/Ralationship	(Type Print)		19b Meili	nn Addres	s (Street				er, City or Town	Stata Zir	(Code)	
		T. Richard									a, Mary			
	20e. Mathod		15/NIECE	20b. P	lece of Dispo	sition (Ne	me of			Data	20c. Location			
		1 2 Cremation 3		Stata	emetery, crea					1. 4,	Hawthor	ne h	Jan Vork	
	4 Donation 5 Other (Specify)  Gate of Heaven Cemetery   2000   Haw  21. Signature of Funeral Service Licensee   Ropert A. Fumphrey Funeral Hom											wthorne, New York		
oue .	16	2 1.1	-	1/001	00 75	bert 57 W	A. I	Pumphre nsin Av	y Fu	neral	Home/B	ethes Chase	da-Chevy , Inc.	
	22a Part1 E	inter the diseese, or co or heart failura. List on	molioptions that o	M001	90 Be	these	da, l	nsin Av Marylan	nd 2	20814-3	3501	1	Approximata	
for use as the burial-transit  clan/Medical Examiner	Immediate Cd disassa or co rasulting in de Sequentially if any, leading causa. Enter Cause (Disas that initiated rasulting in de Immediate Causa)	ist conditions, g to immediata Underlying se or injury sevents	Ь.	Dua to (o dration Dua to (o trolyte	r as a consec	quence of)	:							
by Physician/M			d											
Physician	Part II. Other	algnificant conditions	contributing to de	eath but not rasi	ulting in tha u	nderlying	causa giv	ven in Part I.		23b. Dld t	tobacco use co	ontribute t	the cause of death?	
hy	D.									101	Yaa 2⊠ No	3 Pro	bably 4 Unknow	
by	Бе	mentia							_					
Completed									_		an autopsy rmed?	av	ara autopsy findings allable prior to implation of causa death?	
Comple										101	Yas 2 No	10	Yas 2□ No	
Be C		rafarred to medical						26. Placa of	Death (	Check only o	ne)			
2	axaminar? 1 ☐ Yas		Hospital:	npatient 2 🗆	ER/Outpatier	nt 3 D	OA Oth	ner: 4 🖾 Nursi	ing Homa	5 □ Resid	dence 6 □Ot	har (Specia	(y)	
ation:	27. Manner of 1 X Neture 2 \subsection Accid	el 5 ☐ Pending		of Injury th, Day Year)	28b. Tima o Injury	f_ M	28c. Injui Wo	yat rk? Yes 2 □ No		d. Describe h	how injury occu	rred		
led in by the funeral Certification:	3 ☐ Suicio 4 ☐ Homi		d 200. Place	of Injury - At hong, etc. (Specify	oma, farm, str y)	eet, factor	ry, office		28	f. Location (5 City or Tox	Street and Num vn, Stete)	ber or Rure	el Route Number,	
completely filled in by the funeral Medical Certification:	29e. Cartifiar (Check or one)		Physician: To the aminer: On the be and man											
E 5	29b. Signatura	a and title of certifier	1 2			29		e number			29d. Data sign			
10	1	Ylulyn	le	mur	mu	6	D3.	5791			Decemb	er 30	, 1999	
	30. Name and	addrass of person who	o completed caus	a of death [light]	23a) (Type,	Print)								
	Merlyn	K. Vemury	, M.D.	9801 Ge	orgia	Avenu	ıe,	Silver	Spri	ing, Ma	aryland	209	02	
State		(Month, Day, Year)	32. B	egistrar's Signa					•					
Registrar		TREE 0 9 7		energy	19	An	21/2	1						

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Nema (First, Middle, Last) **Physician** riedlis November 4:00 am 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Trail Way Montgomer 1500 LOST 40tomac 9. Birthplace (Steta or Foreign Country) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** - 4605 1□M 20 F Days Hours 364-12 - 4605 Usuel Residence of Decedent 12 84 Yrs. February Director filed within 72 hours after death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No CA Directo polano 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 230 92075 238 A Avenue 0.5. Funeral 14. Rece - American tndien, Biack, White, atc. Hema Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11 Meditel Status 1 ☐ Yas 2 ☑ No If Yes, Give Å Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Merried 8 Baltimore. Maryland 21215-0020 1 Yas 20 No Specify: Specify: Q 3 ☐ Widowed 4 ₺ Divorced 'netural' Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Sales Ketail other 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Inent of Health and Mental Int: If Item 27 Is marked or Lanari 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 Is any Injury or other tracents. Lunsing MI 48823 nartwell 20b. Ptece of Disposition (Neme of cemetery, cramatory or other place) 20e. Mathod of Disposition Dete 20e. Location - City or Town, Steta 1 D Burial 2 Cremetion 3 Removel from State 11/19/1999 4 Dopation Other (Specify) 22. Name and Address of Facility Anatomic 61ft Foundation 21. Signature of Junerel Se vice Licens 13948 Rathmore Avenue Laur MD 20707 or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, List only one cause on each line. 23a. Part1. Enter the disees Approximete Interval Between Onset and Deeth **Physician** Breast Carenomo Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequenca of): Box 68760. usa as the Due to (or es a consequenca of): of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No 3 □ Probably 4 □ Unknown been signed by Medical Certification: To Be Completed by 24b. Wera autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? certificate has 1 □ Yas 2 No 1 ☐ Yes 2 ☐ No after death. Director: After this certifica d in by the funeral director, i or Attending Physician: 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Mother (Specify) Soris Residence 1 ☐ Yes 2) No 1 Inpatient 3 DOA 2 ER/Outpetient 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending investigation 1 Yes 2 No 28f. Location (Streat end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a, Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day Year)

WINSTON H. LIEND MD

30. Nama and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

1500

4 2000 Signeture

29c. Licensa number

0101022194

BANGGARD ST. STE 103 Alex. Va. 22311

29d. Dete signed (Month, Day, Year)

14/

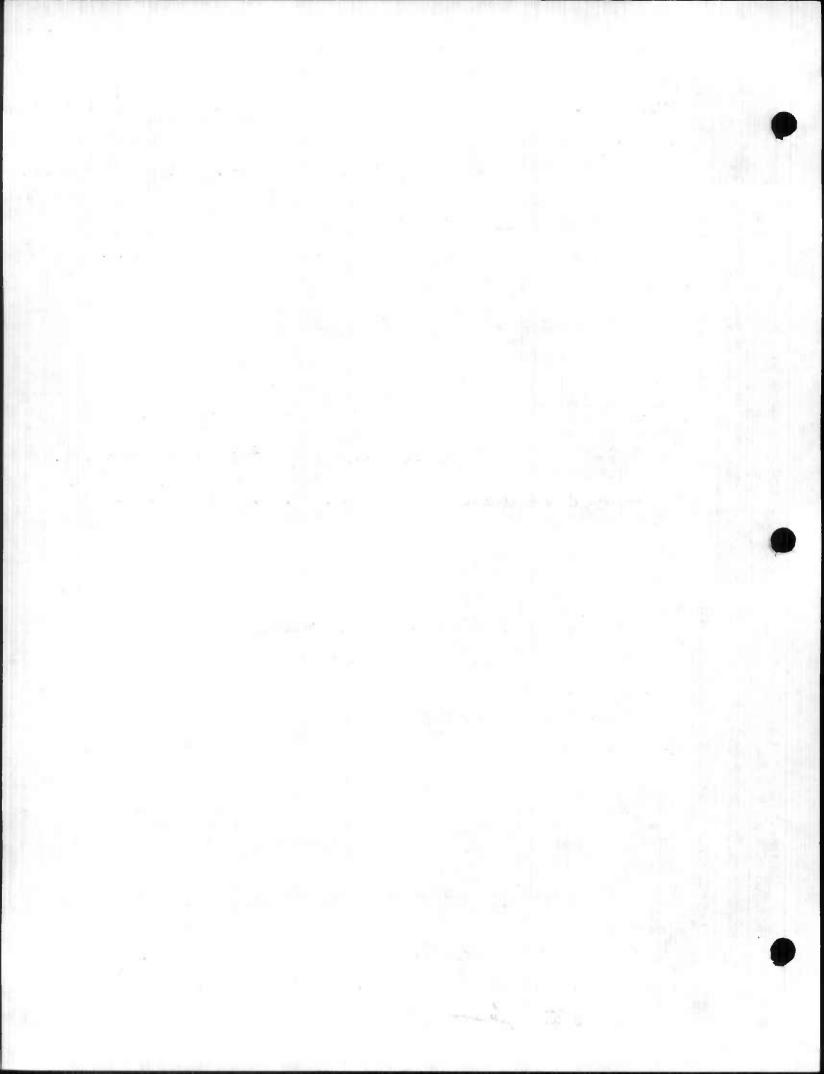
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William 9, 1999 R. Gallion Dec. 11:40 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5314 Blackistone Road Bethesda Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Vrs Oct. 27, 1999 Director N/A Washington, DC. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ital Hygiene. d other than "natural", or itema 23a or 28a-f show avant, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5314 Blackistone Road 20816 U.S.A. death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or ite, any injury or other traumatic avant, the Medical Exercises. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tad Gallion Kristen Schaefer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kristen Schaefer - Mother 5314 Blackistone Road, Bethesda, Md. 20816 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State National Crematory 12/17/99 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses Hornbetten 5130 Wisc. Ave. NW., Washington, DC. 20016 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Cardiorespiratory Failure 1 - 2 Days Examiner Due to (or as a consequence of): Physician/Medical Examiner Apnea and Bradycardia 3 Weeks physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. 4 Weeks Severe Gastro Esophageal Reflux Due to (or as a consequence of): Undetermined Chromosmal Defect 5 Weeks signed by the at I be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Abnormal MRI of the Brain, Hypotonia Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Atrial Septal Defect 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \ Residence 6 \ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of After 1 Neturel 5 Pending Investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier DC12072 12/27/99 oceres 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Bennett, MD. 5225 Connecticut Ave. NW. Washington, DC. 20015 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State JAN 03 Registrar 2000

**DHMH 16 Rav 6/95** 



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				State of Ma	ryland / L	Jepartme Certifica			mental Hy	9	19 42	2527
	u.		1. Decedent's Neme (First, Middle, Las	ot)		Cortino	10 07	Douin	2. Dete of De		3.1	ime of Death
	Physic /Medi		MARIE (	CECILIA GO	RMAN				Month DEC	2819	Year 9:	58 AM
h	Exami		4a. Fecility Neme (If not institution, give	street end number)			4	4b. City, Town, or	Location of Dee	h 4c. County	of Deeth	
			NATIONAL NAVAI			ab do al Hilling	fer 1 Yeer	BETH If Under 24 Hrs			ONTGOME	
	Funeral Director		347-00-0034	ox □ M 2√F	(In yrs. lest bir 85	Month		Hours Min		, 1914	9. Birthplece ( Country) Washing	ton, D.C
	f show	or	Usuel Residence of Decedent  10e. Stete 10b. County  Maryland Prince (		10c. City, Tow Collec	n or Location je Park						side City Limits
	after death with the Maryland or Items 23e or 28e-f show uniner must be notified at	al Director	10e. Street end Number 5207 Paducah Road	i			Zip Code 0740			10g. Citizen of V		
020	urs after at', or its Examine	by Funeral	11. Meritel Status  1 Never Merried 2 Married  3X Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Tyes 2 2 No If Yes, Give Yeer or Detes:	er in U,S.		cedent of Hoecify Cube	ispanic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	Specify	e - American Inc ck, White, etc. White	
Baltimore, Maryland 21215-0020	S and	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+	16a.	Decedent's Us (Give kind of I life. DO NOT	suel Occup work done use retired	ation during most of wo	orking	16b. Kind of Bu	usiness/Industry	
2	filed with Hygiene. ther than sort, the M	Con	Eiementary/Secondery (0-12)			omemake.	r				own hom	e
/land	thould be fill of Mental Hy marked oth matic even	To Be	17. Fether's Neme (First, Middle, Last) William Mitche	ll Hayder	n				E. Pay	n, Meiden Sumen ne	16)	
ar)	the state of		19e. Informent's Neme/Reletionship (7							er, City or Town,		
,≥	and		Mary V. Divver (da	aughter)						ck, Mary		
more	10 H 0		20e. Method of Disposition  **EBuriel 2   Cremetion 3   4   Donetion 5   Other (Specify)		20b. Piece of cemeter	Disposition (A by, cremetory o ston Na	leme of r other plea tiona	nete	ery 1/4/	20c. Location - 2000 Ar1	City or Town, Sington,	
Balt	permit. Pa Departmen Importants any Injury otice.		21. Signeture of Funeral Service Licente	000 M. N.		Dona1	d V.	ss of Fecility Borgward	t Funer	al Home, sville,	P.A.	d 2070s
	_		23a. Pert1. Enter the disease, of comp shock, or heart feilure. List only of	plidations the caused the	ne deeth. Do							oximate vai Between
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	a. APNEA							Onse	of and Death
		ē		D	ue to (or as e	consequence o	f):					
,	icata be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	b	ue to (or es e	consequence o	f):				1	
68760,		edicai	Cause (Disease or injury that initiated events resulting in death) Lest	C. Du	ue to (or es e d	consequence o	f):				1	
Box	death certifi e attending od for use as	Physician/M		d							1	
	the att	rsici	Pert II. Other significant conditions co	ntributing to death but	not resulting in	the underlying	g cause giv	en in Pert I.	23b. Did	tobacco use co	ntribute to the c	suse of death?
s, P.O	res that the de igned by the a be detached (	by Phy							1	Yes 2□No	3 Probably	4 XUnknow
Hecords,	aw requi	Completed							24a. Wes	an eutopsy ormed?	24b. Were au avaliable completi of death?	prior to on of cause
r	The ata h	Con							10	Yes 21 No	1 🗆 Yes	2 No
Vital	Physician: The this certificate ral director, par	Be	25. Wes case referred to medical examiner?	Manada I			l au		ath (Check only	one)		
0	this ald	ြိ	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Mnpatient				4 LI Nursing		Idence 8 Oth		
	After After funer	tion	1 Neturel 5 ☐ Pending	28e. Dete of Injury (Month, Day )		Time of njury M	28c. Injur Wor	yet k? Yes 2 □ No	28d. Describe	how injury occur	red	
DIVISION	I or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Piece of Injury building, etc.				763 2 110		(Street and Numb wn, Stete)	per or Rural Roul	e Number,
	Hospita 4 hours Funeral tely filled	edical Co	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of einer: On the basis of einer end manner state	xaminetion and	, death occurre	d et the tin	ne, date and piac pinion, deeth occ	e, and due to the urred at the time	cause(s) and me dete and piece,	enner as stated.	ause(s)
	within 2 To the	Mec	29b. Signeture end title of court for	end manner stete	· ·	2	9c. Licens	e number		29d. Dete signe	d (Month, Dev. )	(ear)
	10		· Entthe	dam N	10		RES-			29550		
			30. Name and eddress of person who o			Type, Print)				EDICAL C	ENTER	
	-0.	40	ERICH F. WEDAM, I	T, MC, USN			В	ETHESDA	MD 2088	9-5600		
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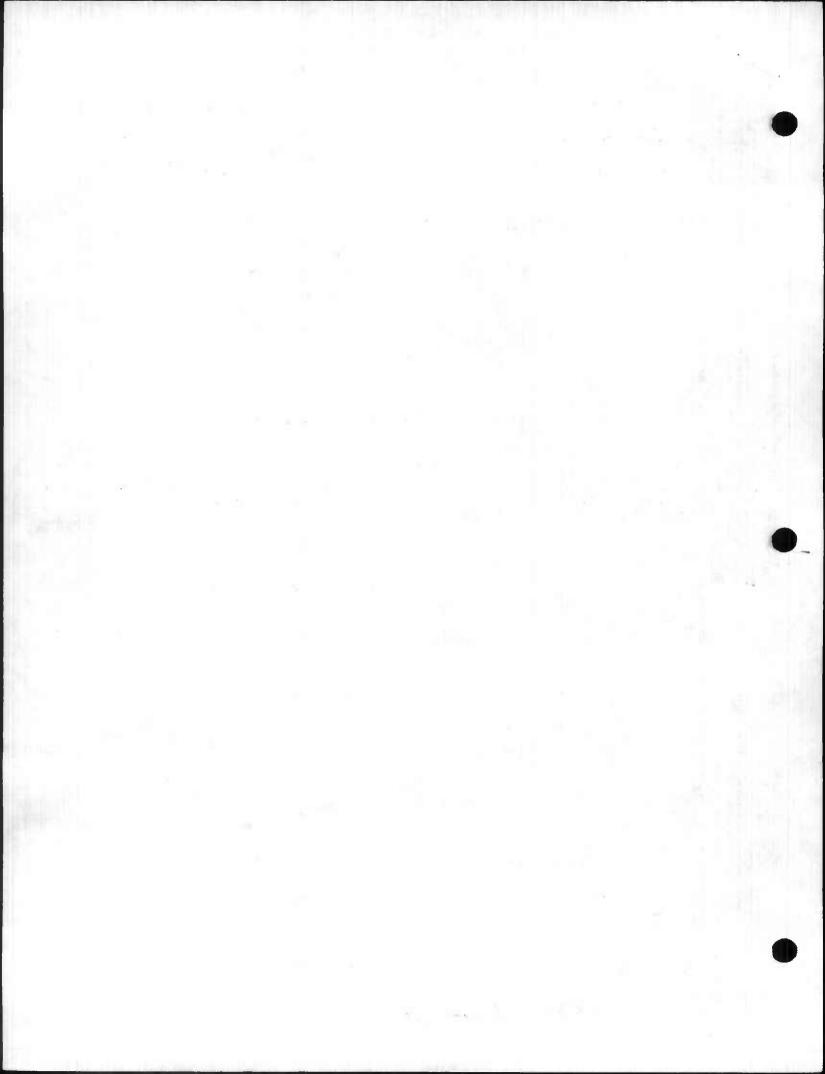
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dec. 18, 1999 Anna Marie Gleber 5:30AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Manor Care-Potomac Potomac Montgomery 8. Date of Birth (Month, Day, Year) 6. 1902 If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Months Days Yrs. 053-52-6970 Germany Director Dec. 6, Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director r than "natural", or items 23s or 28s-f s the Medical Examiner must be notified Maryland Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5324 Albermarle St. 20816 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 Ø No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry it. Pages 1 and 2 should be filed within intrenet of Health and Mental Hygiene. rtant: If Item 27 is marked other than "r njury or other traumatic event, the Mes Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker At Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Schaefer Unknown Eva Unknown 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 5324 Albermarle St., Bethesda, MD 20816 Marilyn Wagner-Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 6 ☐ Other (Specify) 12/22/99 Falls Church, VA National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Jospeh Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Anemia 3 Days disaasa or condition resulting In death) Examiner Due to (or as a consequence of) Examiner 2 Weeks Lower Gastrointestinal Bleed attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause page 2 1 Yes 2 No 1 Yes 2 No Division of Vital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 (XNetural 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital edicai 29e, Cartifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0038781 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Grady, MD 4910 Massachusetts Ave. NW Washington, DC 20016 31. Date filed (Month, Day, Year) 32. Hegistrer's Signature State JAN 03 2000

**DHMH 16 Ray 6/95** 

Registrar

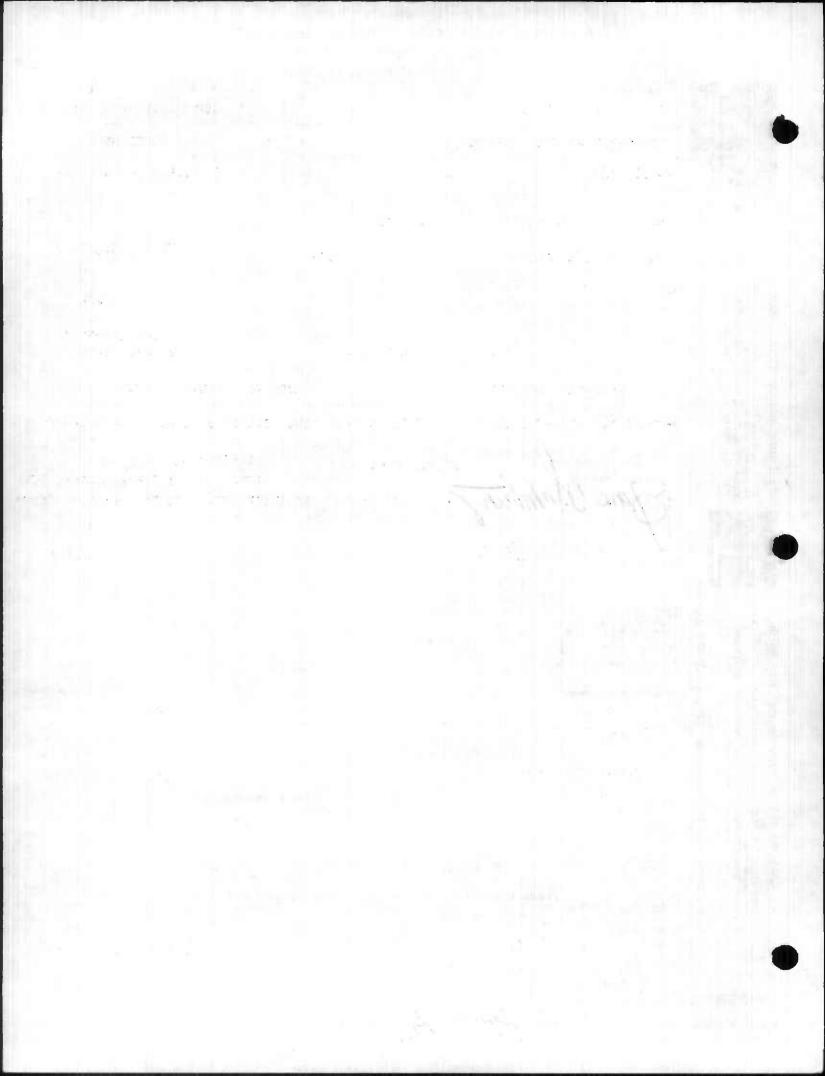


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State of Maryland / Department of Health and Mental Hygiene QQ 1, 252Q

					Certific	ate of	Death		R	eg. No.	22	4636	2
		1. Decedant's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of Dea	ith
Physic /Med		JOE LEE G	ILMORE						DECEMBE			6:25 P	. M.
Exami		4a Facility Name (If not institution,	give street and number)				4b. City, To	own, or Lo	ocation of Death	4c. Count	y of Death		
		MONTGOMERY GENERAL HOSPITAL OLNEY MONTGO											
Funera Director		5. Social Security Number 374–38–5659 Usual Residence of Decedent	S. Sex 7. Ag 1 XM 2 □ F	e (In yrs. last bi	Yrs. If Un Mont	der 1 Yea ns Days		Min.	8. Dete of Birth (Month, Day, JULY 17	,1939	9. Birth Cou MISS	place (State or Fo	reign
land wo		10e. State 10b. County		10c. City, Tow	vn or Location							10d. Inside City Li	imits
death with the Maryland ms 23a or 28a-f show Linust be notified at	Director	MD MONT(	GOMERY	S	ILVER S	SPRIN Zip Code	G		1 1	0g. Citizen of	What Cou	1 Yes 2	] No
ath with 23a or	rai Dir	2612 VILLAGE				209				UNIT	ED SI	TATES OF	
ore, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours effer death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "retural", or items 23a or 28a-1 show other traumatic event, the Healton Examiner must be notified at	by Funeral	11. Marital Stetus 1 □ Never Married 2 ☒ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 XYes 2 1 If Yes, Give Yeer or Dates:			pecify Cu			ecify Yes or No- Rican, etc.)		ck, White	can Indien, , etc. ACK	
5-0 72 hc	eted	15. Decedent's (Specify only highest		18a	. Decedent's U	suai Occu	pation	st of work	ina	16b. Kind of E			
within within then	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)	CONSUI	Tuse retir	ed)		9	U.S.G PRIVA			
d 2 Hygied Hygier Ther.	Ö	17. Father's Name (First, Middle, La	ist)				18. Moth	er's Nam	e (First, Middle, M				
Maryland of 2 should be file th and Mental Hy ?? is marked oth traumatic event	To Be	LEE RUSSELL	GILMORE					ESSII			OWN		
Alary 2 short and N is me		19a. Informant's Name/Ralationship	(Type, Print)	191	b. Mailing Addr	ass (Stree	et and Numb	er or Rur	al Routa Number	City or Town	, State, Z	p Code)	
end 2 ealth a n 27 is		BARBARA E. GILMO	ORE/SPOUSE	2	612 VII	LLAGE	LANE	SII	LVER SPR	ING, MA	RYLAN	ID 20906	
altimore, N mit. Pages 1 end portment of Health portant: If Item 27 Y Injury or other ti		20a. Method of Disposition	A	20b. Place o	of Disposition (	Name of or other pi	ace)		Data	20c. Location	- City or 7	own, State	
Pages nent of I		1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spil		EVERL	Y CREMA	TORY			1/5/2000	FAIRFA	X. V	A	
Baltim permit. Pag Department Important: I		21. Signature of Funeral Service Li	ensee,				ress of Facil	ity HII	NES-RINA			HOME, IN	IC.
<b>o</b> 88558		Mam 1	amount	/.	11800	) NEW	намр					NG,MD 20	
		23a Rangy Enter the disease, or co	omplications that cause	the death. Do	1						0710	Approximate	
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/Medical		Imm ata Causa (Final	SEPS	15							i	1 days	
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	ē			Due to (or as a	Consequence	ory.							
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68 tifical tig phy as th	Med	resulting in death) Last		000 10 (0. 20 2		.,.					i		
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deat deat of fo	sici	Part II. Other eignificant conditions	a contributing to death b	ut not resulting	In the underlyin	g cause g	iven In Part	I.	23b. Dld to	bacco uae c	ontribute	to the cause of de	sath?
P.O.	Physician/	STROKE							1 🗆 Y	00 20 No	3 Pro	obably 4 Unk	nown
S, the street of the de	ò												
Division of Vital Records, P.O. Boy or Attending Physician: The law requires that the death or effer death.  Director: After this certificate has been signed by the ettend in by the funeral director, page 2 should be deteched for us	Completed by	DIARISTE							24a. Was a perform	n autopsy med?	9	Vare autopsy findir vallable prior to ompletion of causi f death?	
Vital Re- vicion: The lav certificate hes frector, page 2	mo	SARLON	00515						1 🗆 Ye	es 25 No	1	☐Yes 2☐No	
m: T	BeC	25. Was case referred to medical					26 Plac	a of Daat	th (Check only on	,			
s cert	ToB	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/O	utnatient 3	DOA O	ther		ome 5 Reside		her (Spec	ifu)	
P. P. O.		27. Mannar of Death	28a. Data of Inju	ry 28b.	Tima of	28c. Inj		0.0	28d. Describe ho			.,,,	
On offine	atlo	1 Natural 5 ☐ Pending 2 ☐ Accidant investigat	(Month, Da	y Year)	Injury M		onk≀ ∐Yas 2.[	No					
VISION Of VITA Attending Physician: ar death. actor: After this certific, by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could no datarmine	ad 286. Place of Inj	ury - At home, f	arm, street, fac	tory, office	9		28f. Location (SI City or Town		ber or Ru	ral Route Number,	
d page in	en	4 🗆 Homicide	building, at	c. (Specify)					City of Town	, State)			
Division of Vital Re- To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate hes ecompletely filled in by the funeral director, page 2	edical (		Phyeician: To the best taminer: On the basis of and manner st	examination ar									
of thing	M	29b. Signature and title of certifier				29c. Licer	nse number		2	9d. Date sign	ed (Month	, Day, Year)	
6		> / ment de	n MD			D	2137	10	9	)ecen	1852	30, 199	19
		30. Name and addrass of person with RAYM 0 MD	no completed cause of d	394/ .	(Type, Print) FELLA	NA	PRIV	E	WHIZE	TON A	10	30, 199	
St	ate	31. Data filed (Month, Day, Year)		ar's Signeture	, ,					1			
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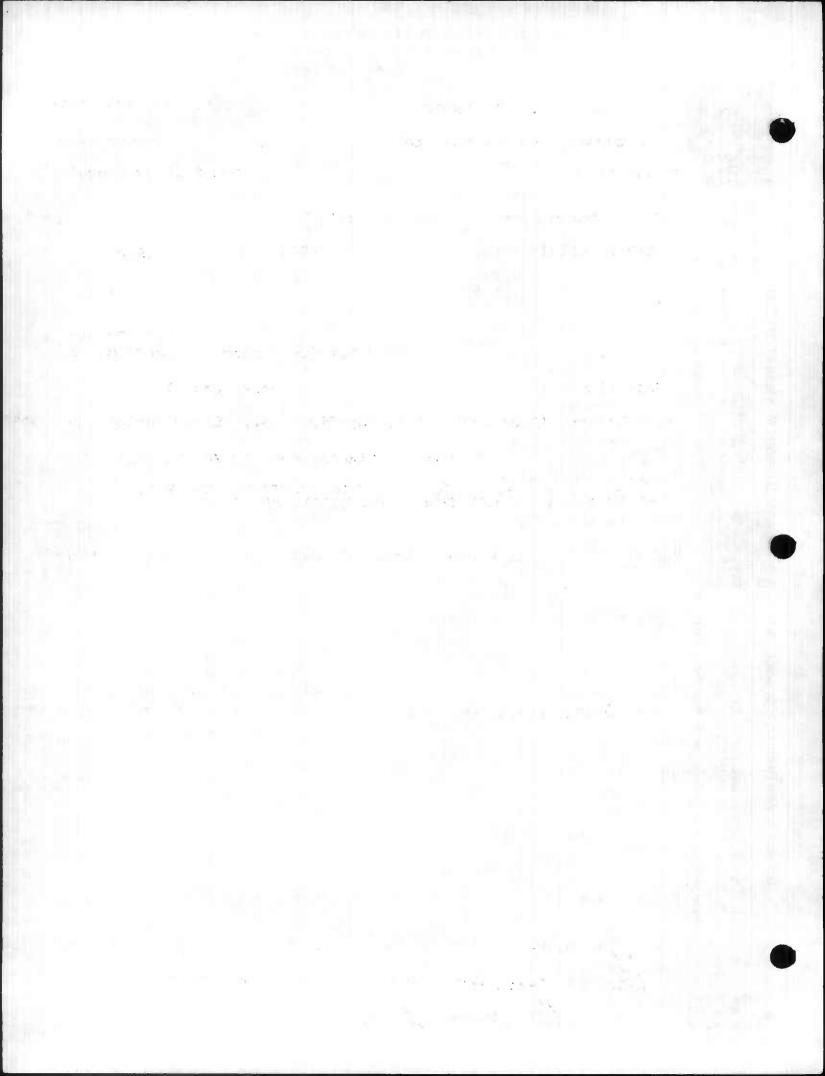
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State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Name (First, Middle						2. Date of D Month	Dav	Year	3. Tima of Death						
/Medical	DAISY	M. GILL	DEC or Location of Dea		1999	1410										
Examiner	4a Facility Name (If not institution, Montgomery	General	Hospita		er 1 Year	Olne	у	MO	NTGO	MERY						
Funeral Director	5. Social Security Number 419-32-1619 Usual Residence of Decedant	6. Sex 7. A	ge (In yrs. last birth 77 Y	Months			in. (Month, D	28, 1922	Geo.	ace (State or Foreign try) rgia						
or 28a-f show a notified at	10a. State 10b. County	gomery	10c. City, Town	or Location ver Sp	orin	ıg			10	0d. Inside City Limits 1 ☐ Yas 2 No						
3a or 28a II Direc	10e. Street and Number 2017 Hopefi	eld Road		10f. Zi	ip Code	0905		10g. Citizen of V		try?						
injury with 12 hours arise been with the maryand they than "natural", or items 23a or 23a-4 show out, the Medical Examinat must be notified at a Completed by Funeral Director	11. Maritai Status  1 Never Married 2 Merri  3 Widowed 4 Divorced	12. Was Decedent Armed Forces and 1 yes 2 M If yes, Give Yeer or Detes:	Ever In U,S. ? No	13. Was Dece		dispenic Origin? en, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	11	America k, White, c	etc.						
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and Mental Hygiene. Is marked other than cumatic event, the M	12th 17. Father's Name (First, Middle, L	V 1	54)	Food S	Serv	ice Wo		Boarde, Maiden Surnem		Ed.						
marked or umatic eve To Be	John Mitche  19a. Informant's Name/Ralationsh		19b.	Mailing Addras	ss (Street		isy Dan	niels ber, City or Town,	Stata, Zip	Coda)						
f Health and Mer tem 27 is marks other treumatic	Mary McCurty 20a. Mathod of Disposition		20h Piace of	Disposition (Na	ema of		l., Silv	ver Spr		MD 2090 wn, State						
5 = 5	Cametery, crematory or other plece)  4 Donation 5 Other (Specify)  Cametery, crematory or other plece)  Geo. Washington Cem. 1/3/00 Adelphi															
Department Important: any Injury phice.	21. Signeture of Funeral Service L	R. Suo	reen	SNOV	VDEN		RAL HOME									
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iding physician and ise as the bunal-transit	Sequentially list conditions, if any, laading to Immediata cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last	b	Dua to (or as a co													
		Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.  23b. Did tobacco use contributions.														
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certificate he rector, page	25. Was case refarred to medical examiner?						1 Death (Check only	Yes 2 No	1[	Yes 2 No						
this of the rall direction of the rall direc	1 ☐ Yes 2 ☑ No  27. Mannar of Death 1 ☑ Natural 5 ☐ Pending				28c. Inju Wo			sidence 8 Oth e how injury occur		у)						
ath.: After the funera	2 ☐ Accident Investig	of he	njury - At homa, far	m, straat, facto	ory, offica			M. Location (Street and Number or Rurel Route Number, City or Town, Stete)								
and Advanced by Institute of the conflicted has been signed by the attert of the funeral director, page 2 should be detached for edin by the funeral director, page 2 should be detached for Certification: To Be Completed by Physicial	3 Suicide 6 Could n 4 Homicide determi	28a. Place of Ir building, e	tc. (Specify)		29a. Cartifier  (Check only one)  29a. Cartifier  (Check only one)  20 Medicat Examiner: On the basis of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.  20 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
n 24 hours after death. Ne Funeral Director: After the platety filled in by the funeral edical Certification:	3   Suicide 6   Could n determi	p Physician: To the best	t of my knowledga, of axamination and													
within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (	3 Suicide 6 Could n determi  29a. Cartifier 15 Certifyln (Check only 2 Medicat E	g Physician: To the best examiner: On the basis of and mannar s	t of my knowledga, of axamination and	or invastigatio	on, in my o	opinion, daath o	ccurred at the time		and dua to d (Month,	o the cause(s)  Day, Year)						

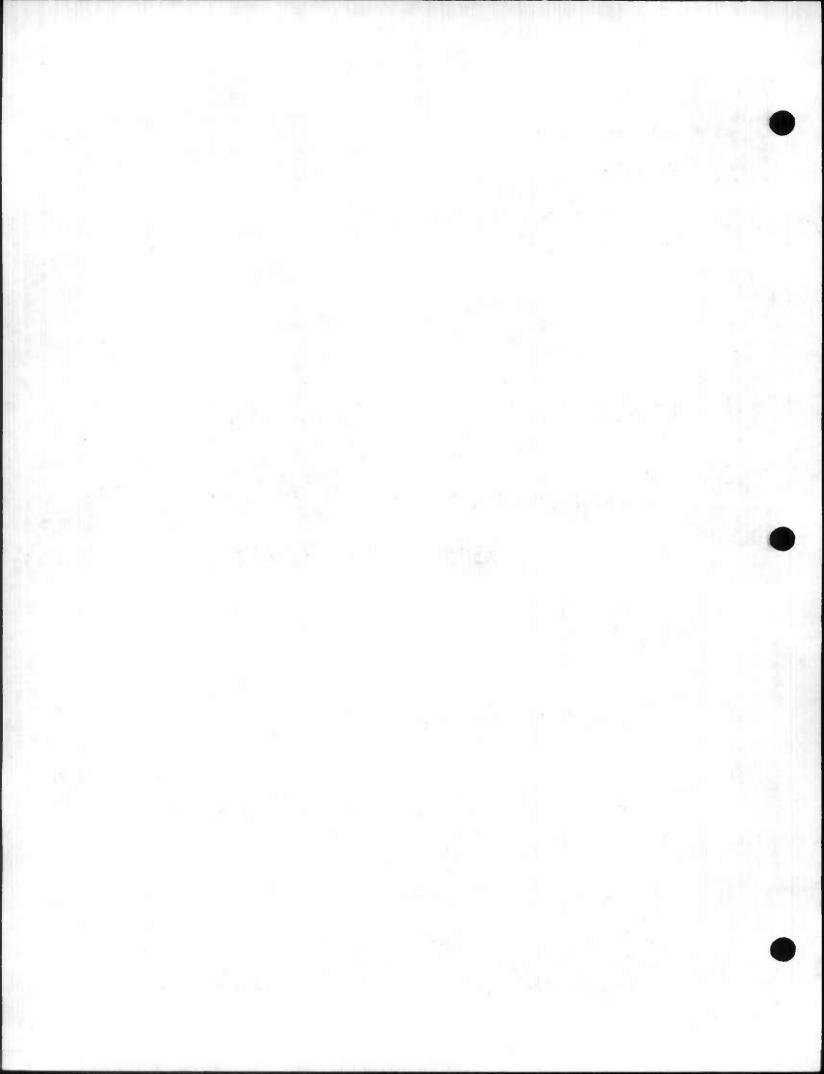
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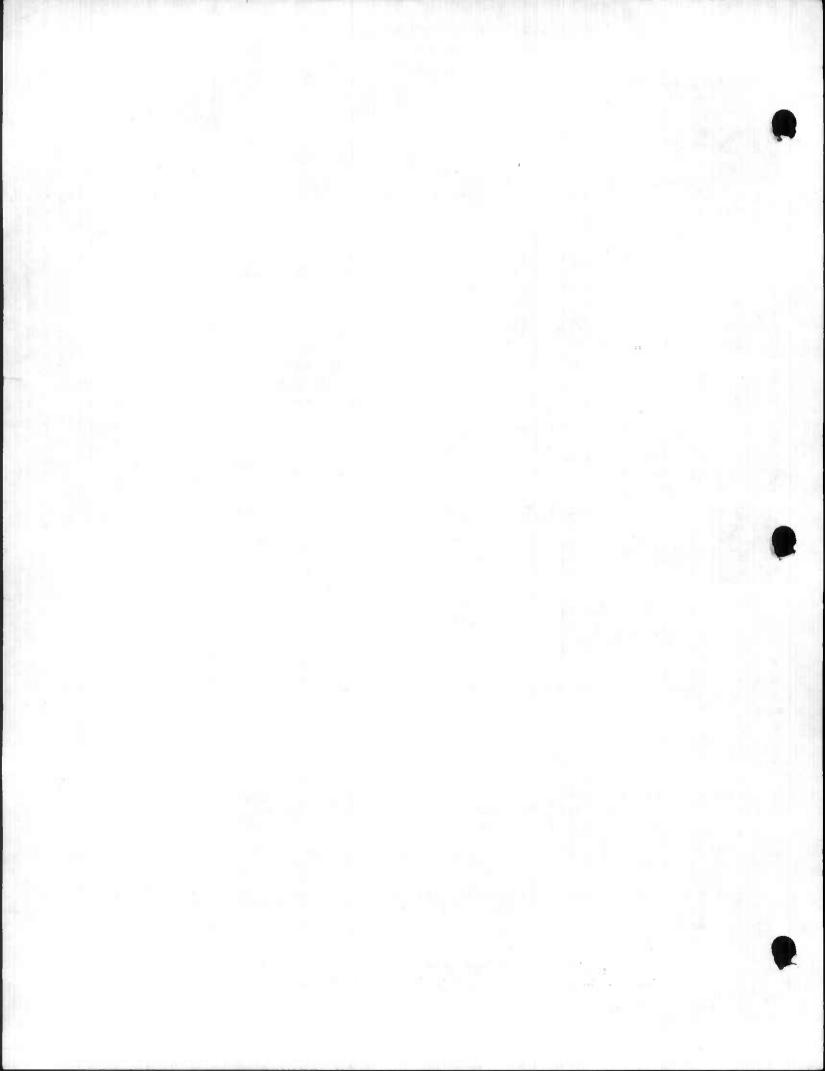
State of Maryland / Department of Health and Mental Hygiene QQ 1, 2521

			Certificate of	Death	Reg. No.	33 4	2001
Physician	1. Decedent's Name (First, Middle, Last) Albert Jacks	on Guynn, Sr			ete of Death lonth Cember 3		3. Time of Death 8:07P.
/Medical Examiner	4a Facility Name (If not institution, give s 11709 Roby Avenue	treet and number)		4b. City, Town, or Location Beltsville	of Death 4c. Co	unty of Death	
Funeral Director	Social Sacurity Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days		ete of Birth fonth, Day, Year) 19.12,1927		ca (State or Foreign
the Maryland 28a-f show solffised at sector	Usuel Residence of Decedent  10a. State 10b. County  Maryland Prince Geo	10c. City, Town				100	d. tnside City Limits 1 ☐ Yes 2√ No
6 5 E	10e. Street and Number 11709 Roby Avenue	9	10f. Zip Code 20705			of What Country	•
020 our after death v et, or thems 23a Examiner man by Funeral	11. Marital Status 1 1 Nevar Married 2 Merried 3XXX/vidowed 4 Divorced	2. Wes Decedant Evar in U,S. Armed Forces? 1	13. Was Decedent of It Yes, specify Cub 1 ☐ Yes 2 ▼ No	tispanic Origin? (Specify Y an, Mexican, Puerto Rican Specify:		Race - American Black, White, et ecity: Wh	
Maryland 21215-0020 32 should be filed within 72 hours at th and Mental Hygiene. The ared other than "natural", or traumetic event, the Medical Exam To Be Completed by F	15. Decedent's Educ (Specify only highast grada Elementery/Secondary (0-12)	completed) College (1-4or 5+)	Decedent's Usual Occup (Giva kind of work done life. DO NOT use retire	during most of working d)		of Bustnass/Indu	
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C 2 M F	19a. Intermant's Name/Reletionship (Type Ralph M. Guynn (se		THE PARTY OF THE P	and Number or Rural Rou Rd. Adelphi,			lode)
Baltimore, North Pages 1 and P	20a. Method of Disposition  1 Burial 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	emoval from State cemetary	Disposition (Name of y, crematory or other pla Washington	Cemetery 1/		ion - City or Town elphi, N	
Baltim permit. Pa Department important: any lejury addis.	21. Signature of Furneral Service License	Tudanell	Donald V. 4400 Powde	es of Fecility Borgwardt Fu r Mill Rd. E	neral Hom Beltsville	e, P.A. , Maryla	and 20705
Physician	23a. Part1. Enter the disease, or complice shock, or heart tellure. List only on	ations that caused the death. Do no couse on each line.	1	_		í í	Approximata ntervet Between Onset end Death
/Medical Examiner	Immediate Ceusa (Finel diseese or condition resulting to deeth)	METASTATI Dua to (or as e c		CARCINOMI			Months
axecuted axecuted in and instransit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c.	Due to (or es a c	onsequence of):				10 11
ecords, P.O. Box 68760, law requires that the death certificate be assected as been signed by the attending physician and 2 should be detached for use as the buriet-transit apleted by Physician/Medical Examir	resulting in death) Last	Due to (or es a co	onsequence of):			1	47.6
Box eath cer attendin i for use	d.						
P.O. Box that the death certified by the attending detached for use a Physician/M	Pert II. Other significant conditions cont SUI PECTED	ributing to death but not resulting in	the underlying causa gi	ven in Pert t.	1 Yes 2 l		1
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The page					1 Yas 2 0		7
Of Vital   Physician: The Physician: This cardificate real director, page 11: To Be Co	25. Was case reterred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 DOA	26. Place of Death (Che	ck only ona)  Residence 6	Other (Specify)	
0 5 5 7	27. Manner of Death 1 Netural 5 □ Pending	28a. Data of Injury 28b. T	ima of 28c. Injury Wo	ry et 28d. [	Describe how injury o		
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicida determined	28a. Place of Injury - At homa, far building, atc. (Specify)			ocation (Street and N ity or Town, State)	lumber or Rural i	Routa Number,
he Hospital in 24 hours he Funeral pletely filled edical C	29a. Certifler Ceptifying Physicians (Check on 2011) Medical Examin	clan: To the best of my knowledge, er: On the basis of axamination end and manner stated.	deeth occurred at the ti	me, date and place, and di opinion, death occurred at	ue to tha cause(s) an tha time, date end ple	d mannar as sta eca, and due to t	ted. he cause(s)
To the To the comp	29b. Signature and little of certifier	My	29c. Licens	se number	29d. Dete s	igned (Month, Di	ay, Year)
( '	30. Name and address of person who con	poloted cause of oaath (item 23a) (	Type, Print) UF G TORK	F ST LAUL	E WIZ	0923	+353
State	31. Dete filed (Month, Day, Year)	32. Registrer's Signeture	4	,			



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State	OI WI	ai yiailu /		rtificate of		wientai i i	Reg. No.	9 1	2532
Physici /Media		1. Decedent's Nam Ruit		o.Lest) Odessa		Ha11				2. Date of Decem	ber 30,	1 999	3. Tima of Death 5:00 AM
Examin		4a Facility Name (46)		n, give street and					4b. City, Town, or Temple				eorge's
Funeral Director		5. Social Security N 246-96-30	lumber 067	6. Sex 1 M 2 X	7. Ag	e (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	-		Birth Pearl 9, 1933	9. Birthp	place (State or Foreign ntry) h Carolina
death with the Maryland the 23e or 28e-f show creat be notified at		Usual Residence of 10n. State	Decedent 10b. County			10c. City, Tov	wn or Lo	cation				1	10d. Inside City Limits
n the Marylan r 28a-f show Lostified at	Director	N.C.	Chowa	n		E	dent	ton					1 Yas 2 No
E 22 E	듬	10e. Street and Nu						10f. Zip Code			10g. Citizen of	What Cour	ntry?
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Vision Attending or deeth. ector: Afte	cati	2 ☐ Accident 3 ☐ Suicide	investig	gation				M 1	Yes 2□No				
Division or Attending effer deeth. Director: Atte	Certification:	4 Homicide	determ	ined 288. P	lace of Injudicing, etc.	ury - At home, f c. <i>(Specify)</i>	erm, sin	eet, fectory, office			(Street and Numi own, Stete)	ber or Run	al Route Number,
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Fun etely	edical	(Check only		Examiner: On th		examination a		occurred at the ti restigetion, in my o					
DIVISION OF To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	¥.	296. Signature and	title of certified					29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
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		Char1	es Boio					ia Avenu	e Silver	Spring	, MD		
Sta Registr		31. Date filed (Mont	n, Day, Year)		2. Registra	ar's Signature	9	South	,				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** ce Harris /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Manor Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth Month, Day, Jan 2, 6. Sex 7. Aga (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1900 1 M 2 XF 99 577-62-1124 Yrs. Washington, D.C Director Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits ham 27 is marked other than "natural", or hema 23s or 28s-f show other traumstic event, the Modical Examiner must be notified at 1 ☐ Yas 2 ☐ No Silver Spring Directo Maryland Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2501 Musgrove Road 20904 United States 2 should be filed within 72 hours efter death in and Mental Hygiene.
Is marked other than "natural", or frema 23s by Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3€ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Meyers Jennie Townsend 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 st Department of Heelth and Important: If ham 27 Ia n any Injury or other traun 3003 Van Ness Street, N.W. S-502 Washington, D.C. Juanita W. Harris 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) Data 20c. Location - City or Town, State 1/6/00 1 ABurial 2 Cramation 3 Removal from State Arlington National Cemetery Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22 Nama and Address of Facility McGuire runeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause of such line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final Phen mon19 disaase or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner ician end buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initiated avants rasulting in death) Last Due to (or as a consequence of): physician s the buriel Division of Vital Records, P.O. Box 68760 certificate be Physician/Medicai Due to (or as a consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t d be detect 200 3 Probably 4 Unknown rain Syndrom 1 Yes þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: effer death. Diractor: After this certific funeral director, 25. Was case refarred to medical examiner? Be 26. Placa of Death (Chack only one) Hospital: Other: 4 Jursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 | Homicide To the Hospital of within 24 hours of To the Funeral D completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29b. Signature and title of certifiend 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and Baltimore Ave

52

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

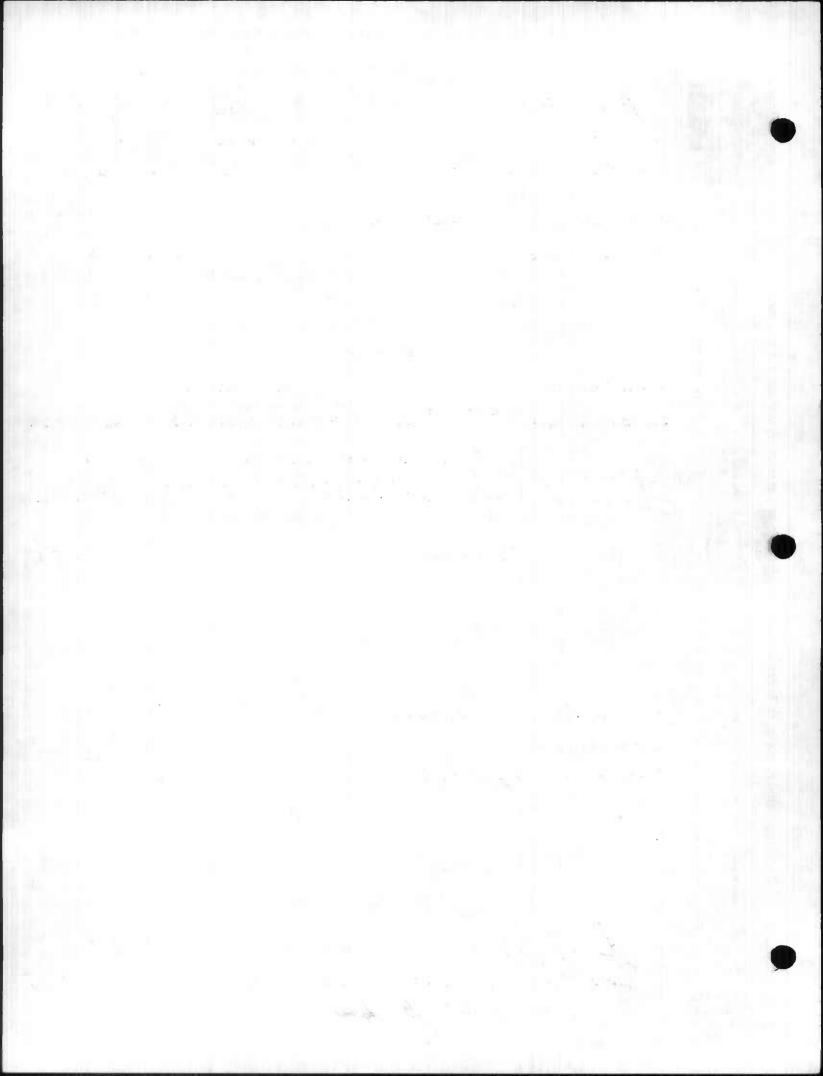
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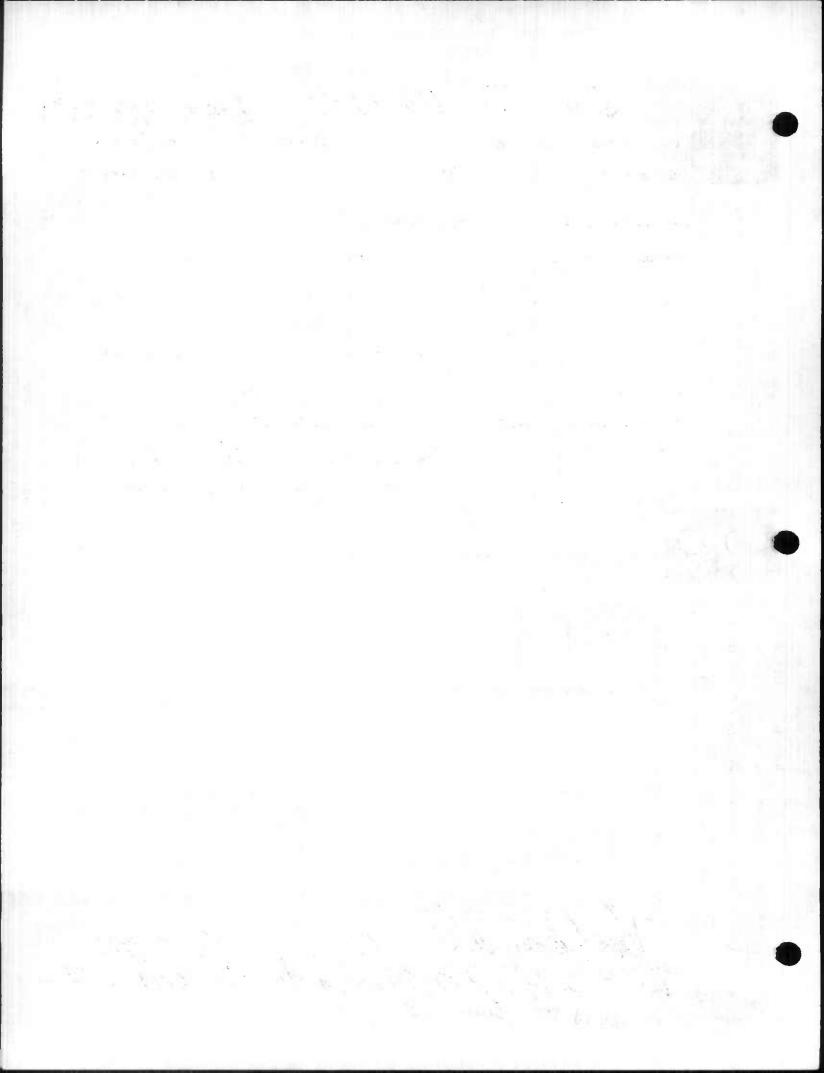


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daath **Physician** OHN /Medical 4a. Fecility Name (If not institution, give streat and number) 4b. City, Town, or L cation of Death Examiner Brooke Grove Nursing Home 01ney Montgomery 6. Sex M☐ M 2☐ F 5. Social Security Number if Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Director 87 Yrs. 163-05-9366 Oct 1912 Virgínia Usual Residence of Decedent the Maryland a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with free mant b 414 Burnt Mills Avenue 20901 Funeral IISA 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian The Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 ☐ Yes 2 No þ Specify: Specify: White 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager/ Owner Service Station other traumatic event, Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is merked oth Be Pages 1 end 2 should be Joseph C. Hawkins Lena Fitzhugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e: If Itam 27 is Eileen Eshleman / Daughter 17415 Applewood Lane, Derwood, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Date Jan 5 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 0 Department important: If 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery any injury 2000 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Francis J. Collins Funeral Home, Inc. Soo 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Entar the diseasa, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one causa on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immadiate Causa (Finat disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be executed ettending physician and for use as the buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 3 Probably 4 Unknown ģ Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy performed? certificate hes 1 Yas 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cesa referred to medicet examiner? Be 26. Place of Death (Check only one) To Other: Wursing Home 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 Other (Specify) 27. Mannar of Death . Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding Invastigation To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi after deeth. 1 Yes 2 - No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature 29c. License number 9d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

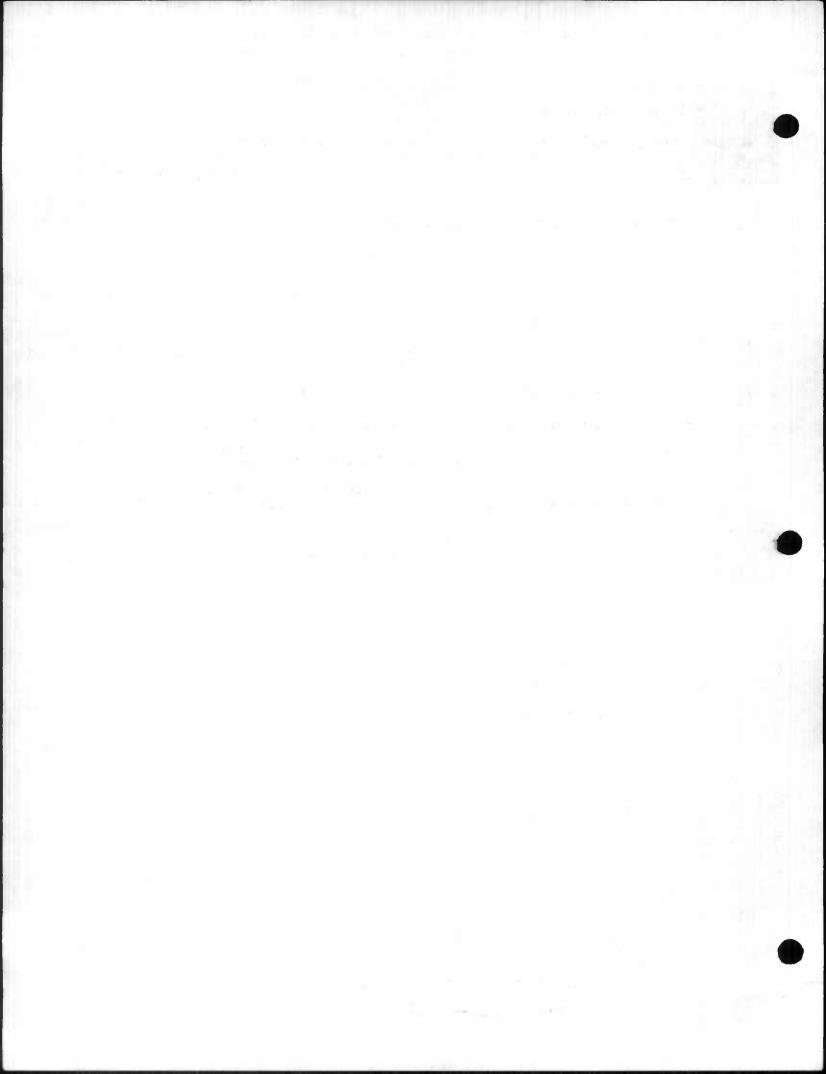
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)	Exami		4e. Facility Neme (If not instituti		num <i>ber)</i>				4b. City, To	wn, or L	ocation of D			y of Death		
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	permit. Peges Department of Important: If It any Injury or once.		4 Donetion 5 Other (Specify)  Parklawn Memorial Park 2000 Rockville  21. Signature of Funeral Service Licensee  22. Name and Addrass of Facility  Francis J. Collins Funeral Home,													
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			James A. Rossi		5 North			-1d	Blvd	S-1	lver	Spr	ino. N	راب راب س عرب	006	
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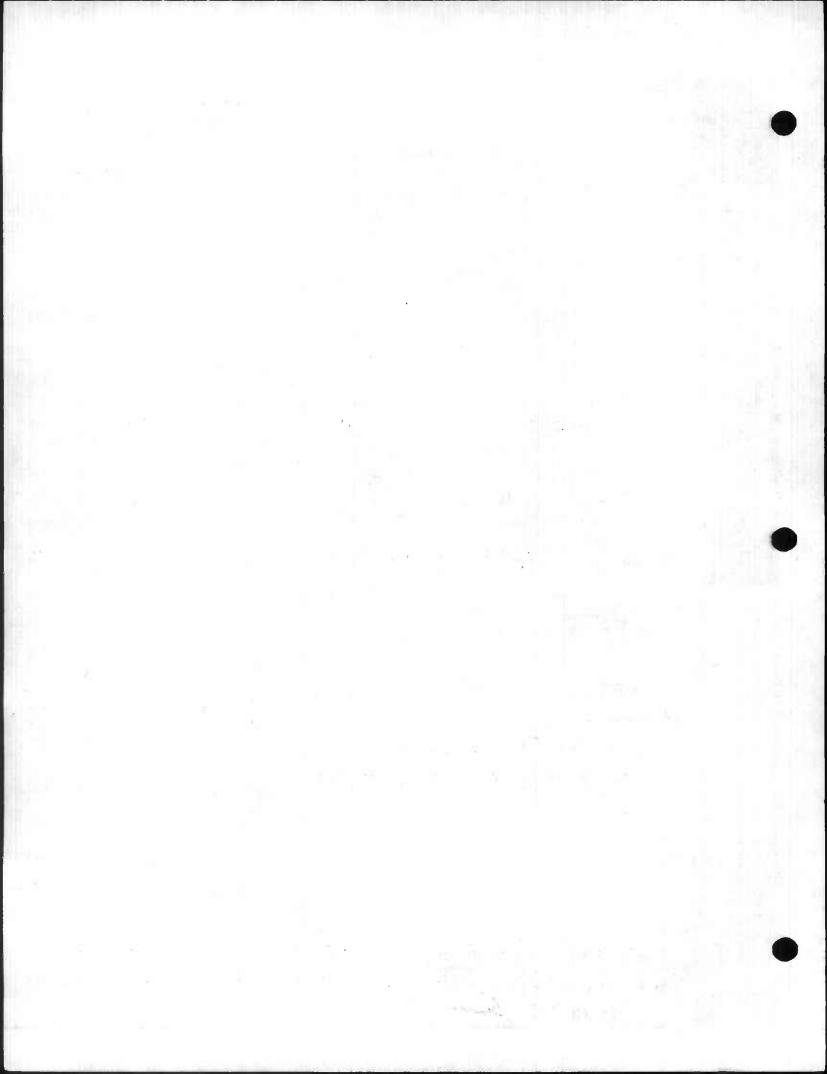
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death 25, 1999 **Physician** DECEMBER 3:43AM JENNIE V. HITCHCOCK /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 M 200 Yrs Director 032-12-7811 80 MAY 8, 1919 MASSACHUSETTS Usual Basidence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Hedical Examinar must be notified at 1 Yas 2 No Director MARYLAND PRINCE GEORGES LANGLEY PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code UNITED STATES 20783 1706 LANGLEY WAY Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours effer. Hygiene. other then "netural", or he 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill iment of Health end Mentel Hamst Hiem 27 le marked out 8 ANNA DINNUCCI LORETO ABITABILE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Reletionship (Type, Print) 1706 LANGLEY WAY LANGLEY PARK, MD 20783 RICHARD HITCHCOCK/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 Cremation 3 Removet from Stata permit. Page Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 12/31/99 BALTIMORE, MD DRUID RIDGE CEMETERY 22. Nama and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funaral Service Licenses 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one cause on each tine. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final CARCINOMA LUNG ZYEARS disease or condition resulting in death) Examiner Examiner physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 987 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown ANemia ģ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed Deep vein Thrombosis completion of cause of death? Stape IV Vacral decubitus 2 No 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case refarred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yes 2 No ည 27. Manner of Death To the Hospital or Attending Pt within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? edical Certification: 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 4203 QUEENSBURY RE Hyattsville MDZ0781 32. Projistrar's Signatura

**DHMH 16 Rev 6/95** 

State Registrar

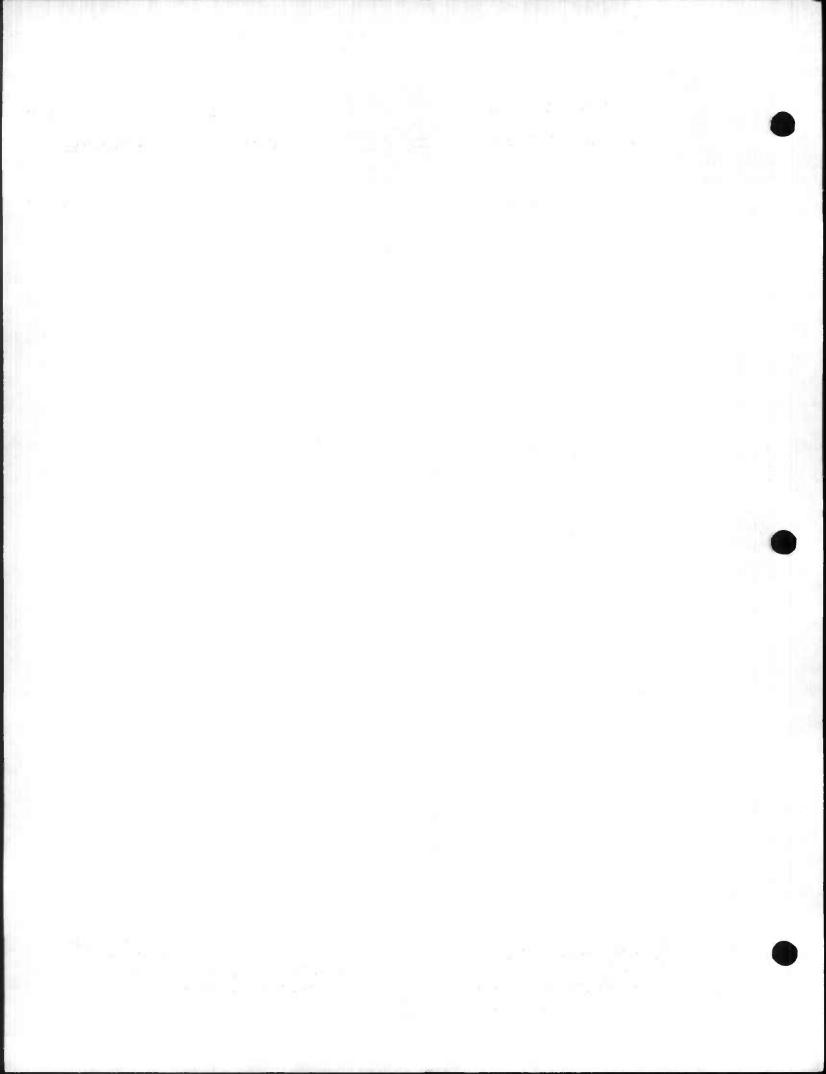
31. Data filed (Month, Day, Year)



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					Cei	rtificate o	f Death		Reg. No.		
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Physicia /Medic		CLAIRE	ANN KENN	EY				DEC		99	9:45 AM
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Funeral			Sax 7 1 □ M 2 🖾 F	. Age (In yrs. I 69	last birthday) Yrs.	If Under 1 Ya Months Day			th y, Year)	9. Birthp	laca (Stata or Foraign itry) ACHUSETTS
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Mery If sh	tor	VA FAIRFA	X	FA	IRFAX						1 Yas 2 No
r 28s	Director	10e. Street and Number				10f. Zip Code	9.		10g. Citizen of	What Coun	itry?
h wit	aiD	6020 BERWYND RO	ΔD				22030		USA		
dea	Funeral	11. Maritai Status	12. Was Deced	ant Evar in U.	S. 13.	Was Decedant of	of Hispanic Origin? (S uben, Maxican, Puar	Specity Yas or No	- 14. Rac	e - Amaric	
permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylend Dispertment of Heath and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examinal must be noticed at once.	þ	1 ☐ Navar Marriad ②☐ Married 3 ☐ Widowed 4 ☐ Divorced		No No		1□ Yas 2∏ N		to ritouri, ato.,		v: WHI	
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es tha igned be de	þ										
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be deteched for use as the burial-transit	Completed							24a. Was	an autopsy ormed?	ava	ara autopsy findings allabia prior to mpletion of cause daath?
Physician: The law requires the third certificate has been signed if if it is certificate the page 2 should be contained to the contained the	E							1 🔯	Yas 2□No	1 🗆	☐Yas 2☐No
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To the Hospital or At Within 24 hours after of To the Funeral Direc completely filled in by	edical		mysician: 10 tha bes miner: On tha bes and manna	is of axaminati	vieoge, deatr ion and/or inv	astigation, in m	tima, data and place y opinion, daath occi	e, and dua to tha urred at tha tima,	data and place,	annar as at and dua to	tha cause(s)
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150		1 12	47			8	3294 (MT)		D. 7	0	1999
8	-	30. Name and address of person who	completed causa	of death (item	23a) (Type			TIAT MED	CAT OFF	men ,	411
			T, MC, US				TIONAL NA THESDA MD			TEK	
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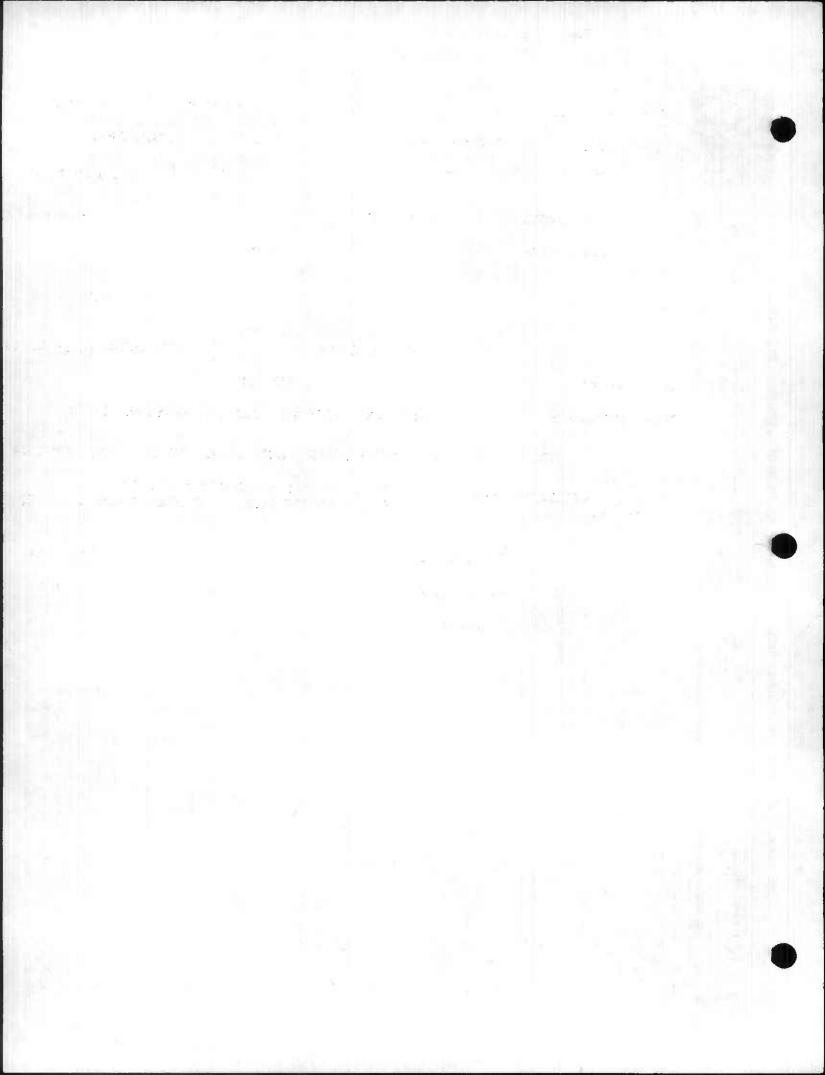
State of Maryland / Department of Health and Mental Hygiene 99 42538

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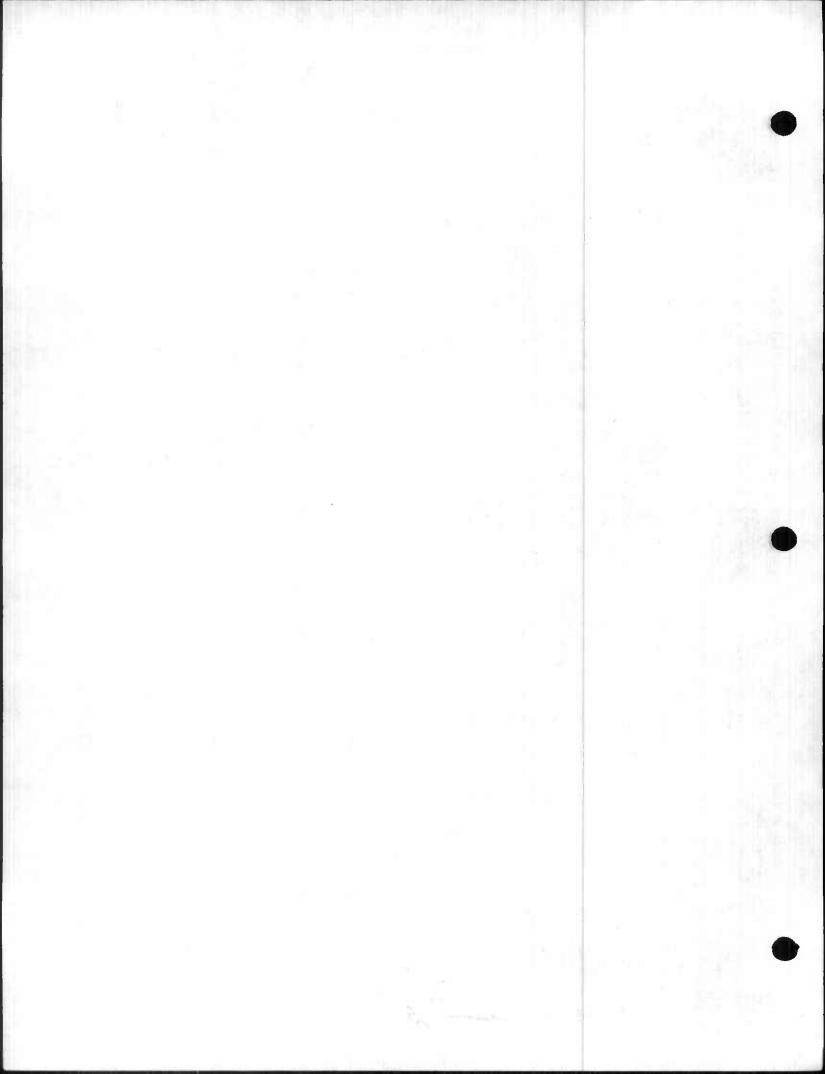
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State of Maryland / Department of Health and Mental Hygiene 00 1.0500

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Physician	shock or heart failure. List only	one cause on each line.							Interval Between Onset and Deeth			
/Medical	Immediate Cause (Final disease or condition	CEDCIC							4 DAYS			
Examiner	resulting in deeth)	e.SEPSIS	ue to (or as a	consequence o	nO:				4 DAYS			
P. 2					.,,							
68760, ificate be executed g physician end es the buriel-transit	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	Di.	ue to (or as a	consequence o	of):		7					
68760, ficate be ex physician is the burial	Cause (Disease or Injury that initiated events	C	e to for es e r	consequence o	<b>0</b> ٠							
- 5 0 0												
IS, P.O. BOX es that the death cert igned by the attendin be detached for use	Part It. Other algniftcant conditions  ISCHEMIC CARDIOMY	d										
the dea	Part It. Other significant conditions	contributing to death but i	not resulting I	n the underlying	g cause g	iven in Pert t.	23b. Did	tobacco uee co	ntribute to the cause of death?			
thet the deteche	ISCHEMIC CARDIOM	ΛΟΡΑΤΉΛ					10	Yes XX No	3 Probably 4 Unknown			
d be d	A ISOMETIC CARDION	IOIAINI					04-144-		24b. Were autopsy findings			
COrds  v requires been sign should be	END STAGE RENAL	FAILURE						s en eutopsy omed?	available prior to completion of cause			
The law require ate has been single 2 should I	d E							7727	of death?			
Vital	8							Yes XXNo	1 ☐ Yes 2 ☐ No			
VISION Of VITAI Attending Physician: T r deeth. ector: After this certificat by the funeral director, p	25. Was case referred to medical exeminer?  1 Yes 2 X No	Hospitel: Mnpatient			0	hor	eeth (Check only					
Phys Phys		28a. Dete of Injury	28b.	tpatient 3	DUA	4 Li Nursing	1	how injury occur				
On dang	1 XX seturel 5 Panding 2 Accident investigation	(Month, Dey Y	(ear)	njury M	28c. Inju Wo	ork? ]Yes 2∐No						
Division for Attending after deeth. Director: After din by the fune	3 Suicide 6 Could not determine	28e. Plece of Injury	- At home, le	orm, street, lact	ory, office				per or Rurel Route Number,			
Die ge	27. Menner of Death  1 X Weturel  2 \( \text{Accident} \)  3 \( \text{Suicide} \)  4 \( \text{Homicide} \)  4 \( \text{Homicide} \)  4 \( \text{Homicide} \)	building, etc. (	(Specify)				City or To	own, Stete)				
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours effer deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	g 29e. Certifier tXXCertifying P	hysician: To the best of r miner: On the bests of ex and manner state	caminetion en	ith occurred at the time, date end place, end due to the ceuse(s) investigation, in my opinion, deeth occurred at the time, date and			ceuse(s) end me , dete and pleca,	enner es stated. and due to the cause(s)				
To the		,			29c. Licen	se number	29d. Date signed (Month, Day, Year)		d (Month, Day, Year)			
(10	1 Spends	an			02134	0		DECMEDE	31. 1999			
10	30. Nema end address of person who	completed cause of dear	th (Item 23a)		14134	·U		DECMEBER	1777			
	RAYMOND A. BASS,	M.D., 3941	FERRAR	A DRIVI	E, WH	EATON, M	ARYLAND	20906				
Stat	31. Dete liled (Month, Dey, Year)	32. Registrar's	s Signeture									
Registra	JAN 0 4 21	JUU- Deman	~ /	9. Se	out							
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Charlotte Lucile Hill Mayhew December 31, 1999 14:06 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) April 3, 1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2以F Months Hours 85 274-66-0975 Director Michigan Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director 28a-fi Franklin Columbus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Berns 23s 43221 3526 Rue de Fleur United States Funeral al Hygiene.

I other than "natural", or flammerer, the Medical Examiner in 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White ğ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fleen 27 is manked otha any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry S. Hill Della Merrill 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Ann Mayhew/Daughter-in-law 10812 Admirals Way, Potomac, Maryland 20854 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 1 D Burial 2 Cremation 3 Removal from State Evergreen Cemetery 2000 Streetsboro, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licens MUU803 | Bethesda, Maryland 20814-350

23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical Ventricular Fibrillation Minutes Examiner Due to (or as a consequence of): Examine Acute Myocardial Infarction Minutes sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical Due to (or as a consequence of): 82 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Certification: To 1 ☐ Inpatient 2 Ĭ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division or Attending 1 X Neturel 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edicai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

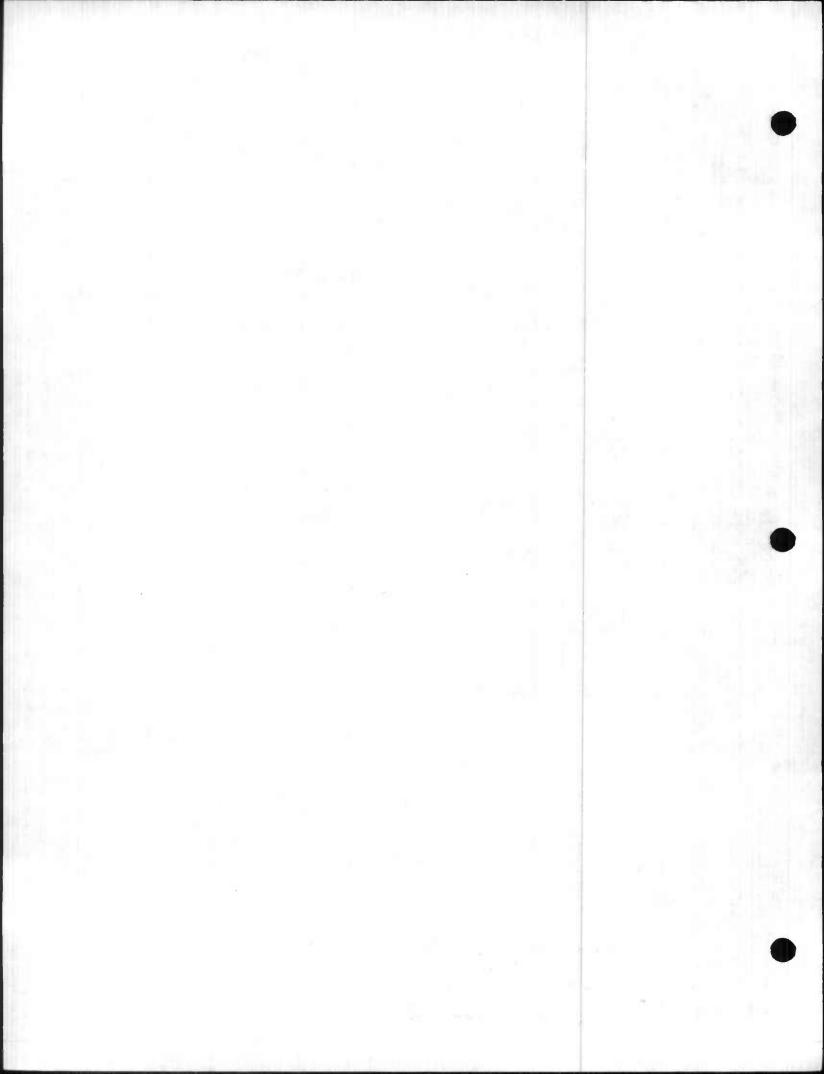
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier hey 10 D47093 December 31, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Thai McGreivy, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

**DHMH 16 Ray 6/95** 

State

Registrar

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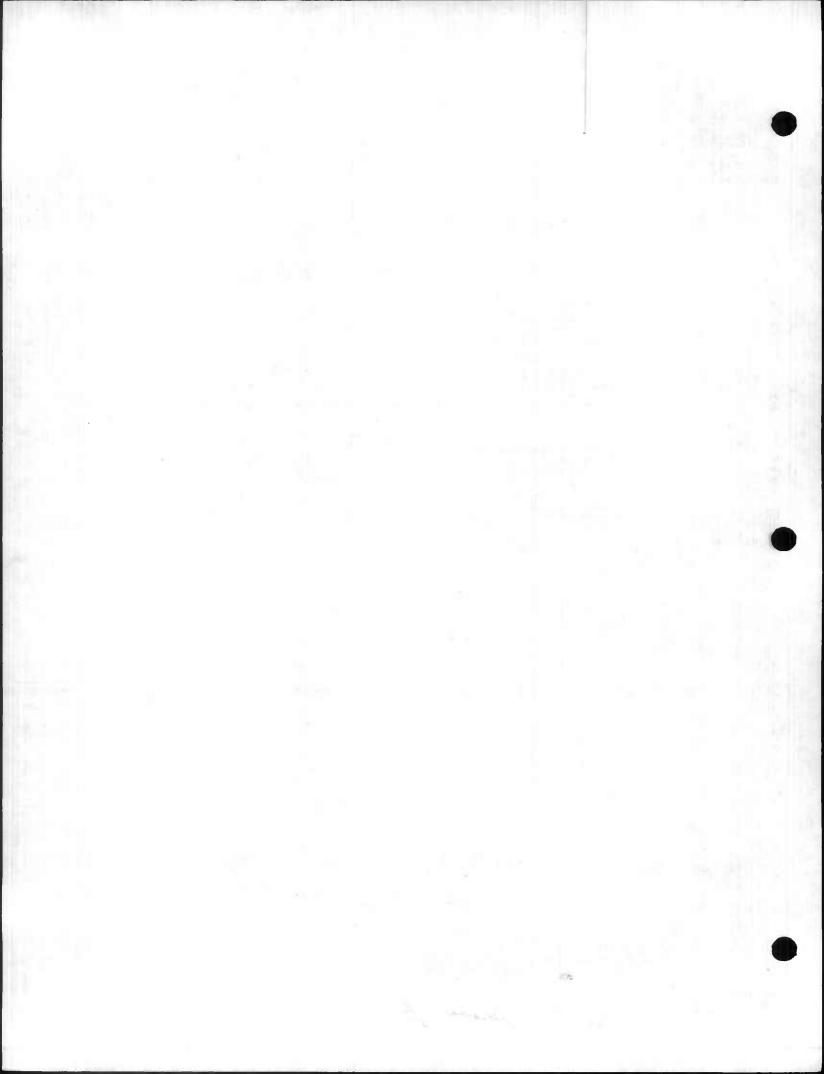
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 30, 1999 **Physician** Viola Lucile Marquardt December 4:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6104 Wayside Drive Rockville Montgomery ar If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Ye Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2XF Director 87 October 11, 1912 Missour: 215-32-3610 the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a or 6104 Wayside Drive 20852 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Wes Decedent Ever in U,S. Armed Forces? Bleck, Whita, etc. r than "natural", or lier the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 NWidowed 4 Divorced Year or Dates. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

I marked other than "
umetic event, the Mex Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy
important: if Item 27 is marked other
any injury or other traumetic event. 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Celia Idona Johnson Eli John Elkins 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 6104 Wayside Dr., Rockville, Maryland 20852 Neil E. Marquardt Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete 1/4/2000 Norfolk, Nebraska Hillcrest Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanse 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Multiple infarction dementia 2 years Examine Due to (or as e consequence of) Examiner Cerebrovascular disease sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 8 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? been signed by the s should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Š 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? ate has page 2: 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNetural 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) ş 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 ent December 30, 1999 0 D00143 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hubert J. Alpert, M.D., 8630 Fenton St. #230, Silver Spring, Maryland 20910 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State souls Registrar 2000

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Data of Death Month **Physician** John Edward Miller December 26, 1999 1:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec 9, 194 Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10XM 2□ F Months Hours 51 Yrs. 1948 Director 218-52-8355 Maryland Usual Residence of Deceden with the Maryland Pages 1 and 2 should be filed within 72 hours after deeth with the Marylannent of Health and Mentel Hyglane.
Int: If Hem 27 Is marked other than "natural", or home 23a or 28a-1 ehow Irry or other traumatic avant, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code To 3419 Floral Street 20902 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, atc. 1 □Xas 2 □ No 1968 – M Yes, Giva Year or Datas: 1971 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Park & Planning 12 Heavy Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B James Henry Miller Margaret E. Royce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3419 Floral Street, Wheaton, MD 20902 Maria S. Miller/ Wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or page. 12/29/99 SIlver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature 75 Funeral Service Licenses 22. Name and Address of Facilit Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction several hrs Examiner Dua to (or as a consequence of): Examiner Chronic Congestive Heart Failure physician and the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) for use es P.O. signed by the s d be detached f Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4X Unknown Essential Hypertension Records, ģ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Non-Insulin Dependant Diabetes Mellitus lector, page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No Morbid Obesity Division of Vital or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yas 2 No e Hoophal or Attendit n 24 hours after deeth. e Funeral Director: A sletaly filled in by the fu deeth. investigation 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only anel 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

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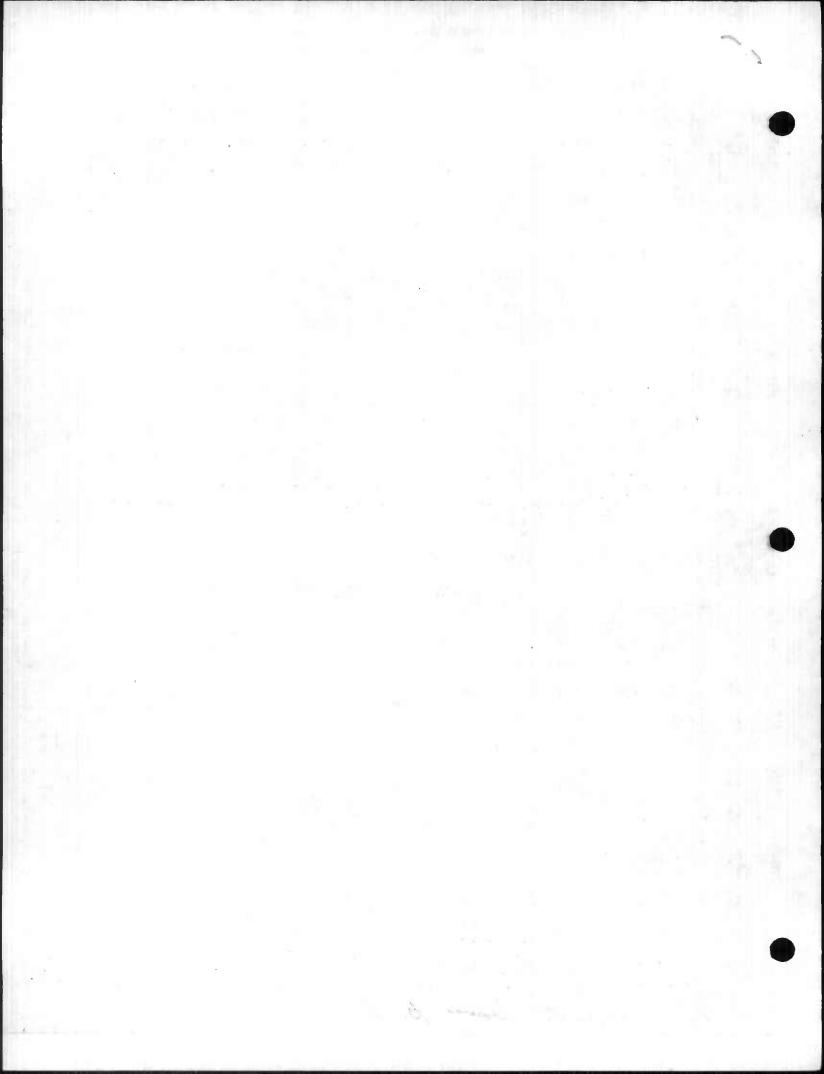
31. Date filed (Month, Day, Year)

Charles L. Franklin, Jr., 32. Registrar's Signature oaks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

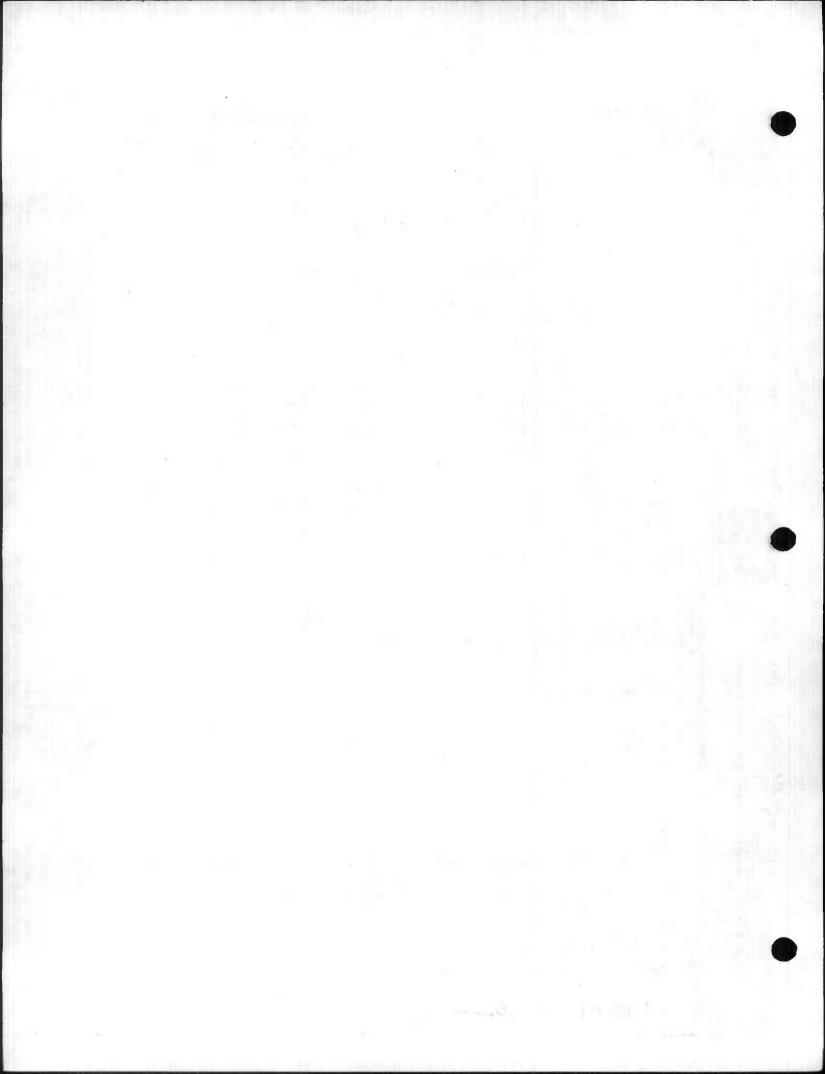
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11120 New Hampshire Ave., #408, Silver Spring, MD 20904



State of Maryland / Department of Health and Mental Hygiene 99 42543

					C	ertifica	te of	Death			Reg. No.			
		1. Decedent's Name (First, Middle	, Last)							2. Date of Dec	ath		3. Time	of Death
	Physician	Charles V Move	•							Month	er 30,	Year 1 Q Q Q	2.3	3 pm
	/Medical	Charles V. Moye  4a Facility Name (If not institution)		umberl				4h City To	wn or L	ocation of Death		-	2.5	э bш
	Examiner		9,70 31 001 1170 111	unicory										
_		413 Lanark Way	0.0-	- A - A-	1 .11.4	. Hillada	r 1 Year	Silve			Montg			
	Funeral		6. Sex 1. M 2 ☐ F	7. Age (In yrs	. last birthda Yrs.	Months	Days		Min.	8. Date of Birt	, Year) 1930	9. Birthpl Coun	iace (Stat try)	e or Foreign
ı.	Director	579-34-1799		69	115.					reb 14	, 1930	New Y	ork	
	P .	Usual Residence of Decedent  10e. State 10b. County		10- 0	in Taus as	1 continu						Ta		
	anyle anyle	Toe. State		106. 0	ity, Town or	Location						11		City Limits
	ct of	Maryland Montgo	mery	Si	lver S	Spring							1 🗆 🔻	88 ZLJNO
	or 2	10e. Street and Numbar				10f. Zi	Code				10g. Citizen of	What Coun	try?	
	hwith will be a sea	413 Lanark Way				209	01				USA			
	ther deeth with the Ma r frame 23s or 23s-f a nine must be notified Funeral Director	11. Marital Status		cedent Ever in U	J,S. 13	3. Was Dece	dent of	Hispanic On	gin? (Sp	ecity Yes or No- Rican, etc.)	14. Re	ce - America		
0	F. Fr.	1 Never Married 2 Marri	Armed F ed 1 1 Yes	2 No 1 Q	51_				i, Puerto	Hican, etc.)	Bla	ck, White,	etc.	
2	by	3 Widowed 4 Divorced	If Yes, G	114.0		1 Yes	26) No	Specify:			Specif	y Whit	e	
Ō	S ho	15. Decedent	s Education		16a. Dec	cedent's Usu	el Occu	pation			16b. Kind of B	usiness/Ind	Justry	
12	led within 72 ho hygiena. her then "neturn nt, the Medical Completed	(Specify only highes			(Gir	ve kind of w	ork done	during mos	t of work	ing				
2	with the D	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)	Engin	neer					NASA			
0	H H	17. Father's Name (First, Middle, L	ast)		1-1-8-1-1			18. Mothe	er's Nem	e (First, Middle,		ne)		
an	antel H ed off	Chamles I Mana						E1		C+1-	4			
2	Men	Charles J. Moye			405 34-	Marian Andreas	- 101	1	-	Sincla		Otata Sia	0.4-1	
Maryland 21215-0020	12 s h an reu									al Route Numbe			C009)	
	fealth m 27	Marion W. Moyer	/ Wife	not-				ly, Si	lver					
0	T The Table	20a. Method of Disposition  1 Burial 2 Dicremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, cremetory or other place)							į	Dete	20c. Location	- City or To	wn, Stete	
Baltimore,	A Parity Par	4 Donetion 5 Other (Sp			tropol	itan	Crem	natory	1	2/31/99	Alexan	dria,	VA	
at	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic avant, the Medical Estaminar must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service L	icensee			22. Name a								
n	80E 8 8	1 4	Francis J. Collins Funeral Home, Inc.											
		500 University Blvd., W, Silver Spring, MD 20 23a. Park. Enter the disease, or complications that can be death. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate												
		shock, or heart failure. List of	nly one ceuse on	each fine.	an Bonot o	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	30 o. ay.	, , , , , , , , , , , , , , , , , , ,	0210100	or roops atory or	1001,	1	Interval E Onset an	Between
	Physician /Medical	Immediate Cours (Final										F F	011001 011	o Douth
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		resulting in death)		Due to (	or es e cons	equence of)	:					1		
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	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the bunal-transit completed by Physician/Medical Examiner	Sequentially list conditions,	0	Due to (	or es a cons	equence of)	:					İ		
Ç	iniat.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										1		
68/60,	ysic hab	Cause (Disease or Injury that initiated events	с	Due to (	or as a cons	equence of):								
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0	res that the designed by the a libe detached if it by Physic	Part II. Other significant condition	ial contributing to c	seath out not res	sulting in the	underlying	cause gi	ven in Part i	•					
7	that ded by deta									10	rea 2 No	3 ☐ Prot	sably 4	Unknown
Hecords,	signer of the d											T 0.45 MI.		# · # · ·
0	The law require rate has been signated page 2 should to Completed									24a. Was perfo	an autopsy med?	av4	ailable prid	sy findings or to
Ö	as by 2 st pie											of c	mpletion of death?	or cause
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A Ital		25. Was case reterred to medical	1					26 Place	of Deat	h (Check only o	nel			
	ysician: The law s certificate has director, page 2 To Be Comp	axaminer? 1 ☐ Yes 2 ☒ No	Hospitel:	Inpatient 2	1 E D/Outpoti	iont 3 D	Ot Ot	hor		ome 5X Resid		har /Ensaih	a k	
0	6 6 5	27. Mapner of Death		of Injury oth, Day Year)	28b. Time		28c. Inju		-	28d. Describe h			7	
5	Afte fund	1 Netural 5 Pending		nth, Day Year)	Injury	M		rk? ]Yes 2.⊟						
DIVISION	tal or Attending Physician: rs after death. al Director: After this certificated in by the funeral director, Certification: To Be (	3 Suicide 6 □ Could n	ot he	o ot loium. At h	omo in m					28t. Location (S	Street and Num	her or Rura	I Pouto N	umbar
<u>≥</u>	or A Street in by	4 Homicide determin	build	e ot Injury - At h ling, etc. (Speci	ify)	sireet, tactor	y, onice			City or Tow		oor or more	THOUSE IN	umber,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	37		Dillo Vice II										
	in 24 hours he Funer pletsly fill edical	(Check only 2 Medical E	Physician: To the baminer: On the b	e best of my kno basis of examina	owledge, dea	ath occurred investigation	et the ti	me, date an	d place, th occur	end due to the	cause(s) and m	anner es st	ated.	e(s)
	the the splet	one)	and mar	ner steted.							prade,			-1-7
	To T	29b. Signature end title of certifier 29c. Licen.							0		29d. Date signed (Month, Day, Year)			
								792	8		12/	31/9	5	
	12+1	30. Name and address of person who completed gause of death (Item 23					12	Rahado	ri	M.D	- 1			
		10301 Geo	asia Av	e S	luge	Sprin	S	70 Z	090	7				
		31. Date tiled (Month, Day, Year)		Registrar's Signa		7	, ,		- 1					
	State		ກກາ 🌋	Lease of Sign	4	In	1	1						



State of Maryland / Department of Health and Mental Hygiene Q 42544 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 29, 1999 11:50 am Helen Vetta Mode /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 10, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Hours Months Tennessee 78 Director 386-12-9819 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 USA 6703 Fortieth Avenue deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Espans Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) Clerk A&P Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andy J. Proffitt Susan Pierce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 14640 Russell Ave., Allen Park, MI Pauline Proffitt / Sister 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/00 Brentwood, MD Fort Lincoln Cemetery 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. lles 500 University Blvd., W, Silver Spring, MD 20901 23a. Far1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet 30 minules disease or condition resulting in death) Examiner Examiner Disease physician and the burial-transit the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events Due to (or as a cons Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a cons for use as 158 signed by the a d be detached f Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. þ 24b. Were autopsy tindings available prior to should Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata director, 25. Wes case referred to medical examiner? 89 26. Place of Death (Check only one) Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer or Attanding 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of exa and manner stated. (Check only one) nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 5 29d. Date signed (Month, Day, Year) 12 (Item 23a) (Type, Print) OCARROL 30. Name and address of person who co AVE, TAKOMA PARK, MI MOBARAK

**DHMH 16 Rev 6/95** 

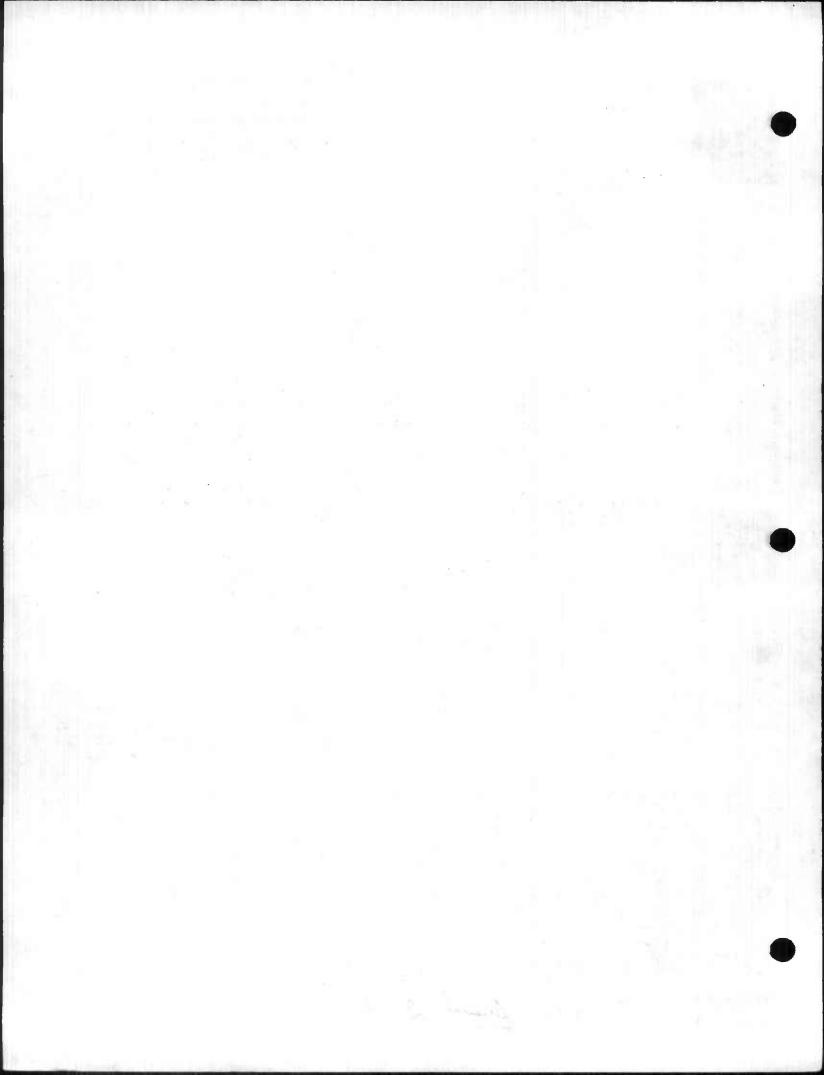
State

Registrar

31. Date filed (Month, Day, Year)

**JAN 03** 

32. Pegistrar's Signature

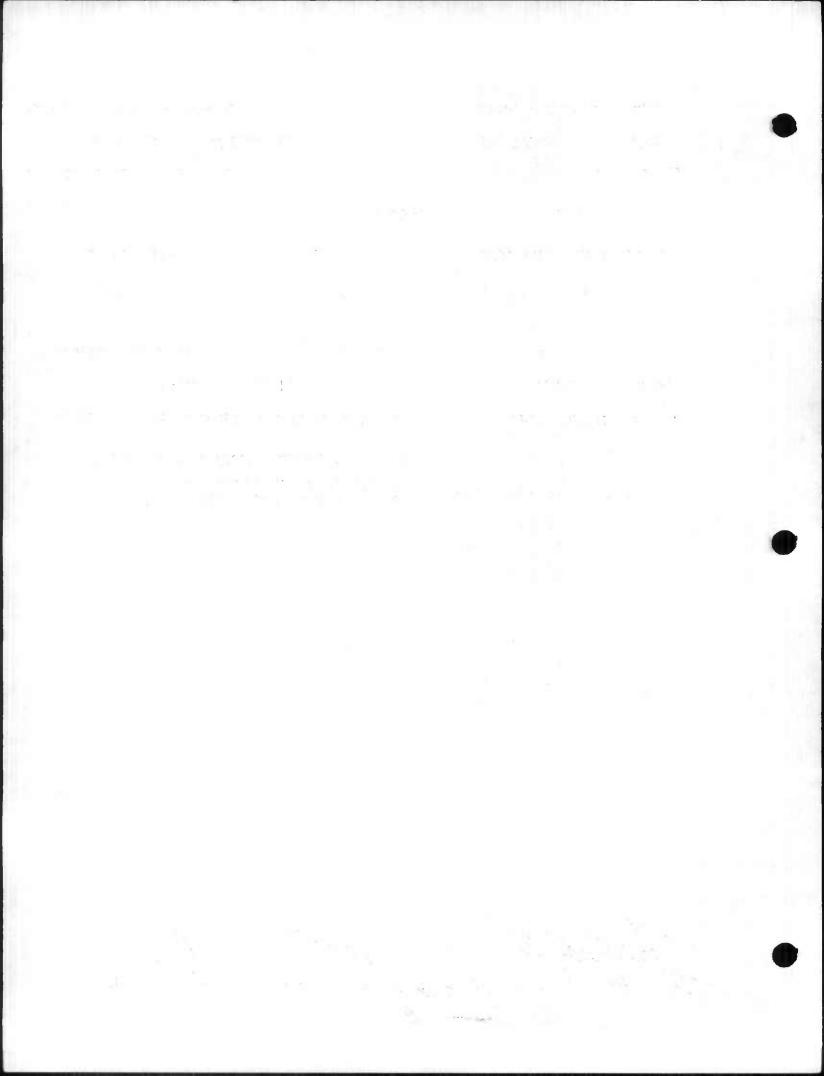


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 4 2 5 4 5

						Certificate of	Death		Reg. No.		
	Dharis		1. Decedant's Nama (First, Middla, Las	st)				2. Data of De		Year	3. Time of Death
	Physici /Medi		JOHN FRANCIS	MILLER				DECEMB			6:10 PM
	Examir		4e. Facility Nama (If not institution, give	street and number)			4b. City, Town, or L	ocation of Deeth			
			1011 QUAKER R	KNOLL ROAD				PRING	MONTO	OMER	Υ
	Funeral		Social Sacurity Number     6. Se	SZM OFF	(In yrs. last bin	Months Devi		6. Dete of Birl	th v. Year)	9. Birthpi	ece (Steta or Foreign
1	Director		5/9 48 6048	9	1	Yrs.		AUG. 3	,1908	ILLI	NOIS
	p .		Usuel Rasidence of Decedant  10a. Stata  10b. County		10c. City, Town	or Location				140	N. 1
	show	ř	N.H. CARROLL			CORUA				10	od. Inside City Limits  1 ☐ Yes 2 ☐ No
	the Man 28a-f sh notified	Director						1			
	No.	5	10e. Street and Number	TI I DOAD		10f. Zip Code	17		10g. Citizan of W		•
	72 hours after death with the Meryland naturel', or fterne 23a or 28a-f show dreal Examinet must be not used	Funeral	464 WASHINGTON H			038			UNITED		
	er de	ů	11. Meritei Stetus	12. Wes Decedant Ev Armed Forcas?		13. Wes Dacedent of If Yas, specify Cu	Hispanic Origin? (Sp ban, Maxican, Puerto	pacify Yes or No Ricen, etc.)	- 14. Race Biaci	- Amarica , Whita, a	
20	s aft	by F	1 Navar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas:	)	1□Yas 212 No	Specify:		Specify:	WHIT	ΓE
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lan	ould be Mental arked o	To Be	FRANK L. MILLE	R			MINNIE	E'	YERLY	1	
Maryland 21215-0020	2 should b and Menta is marked raumatic e	F	19a. informant's Name/Raiationship (T		19h	Mailing Addrass (Stree	at and Number or Ru	ral Routa Numbi	er City or Town	Stata Zin	Code)
	s 1 and 2 should be filed ( Health and Mental Hyg tem 27 is marked othe other traumatic event,			WIFE		011 QUAKER					
Baltimore,	Heart Street	İ	20a. Method of Disposition		20b. Piace of	Disposition (Name of	5514	Dete	20c. Location - 6	City or Tov	wn, Stete
10	ages ant of t: H h		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			y, c <i>rematory</i> or other pi POLITAN CRE		2/30/99	ALEXAN	DDTA	VA
=	ortan Injur		21. Signature of Funeral Sarvice Licens		TIL TITO					DIVIA :	, 17.
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		muriel D	. Barber	)		BARBER F				
							5038, LAY			20882	
J.			23a. Part1. Entar the disease, or comp shock, or haart fallure. List only of	ona cause on each lina	na geeth. Do r	lot antar tha moda of dy	ring, such as cardiac	or raspiratory at	rrest,	1	Approximata Intarval Between Onsat and Death
	Physician /Medical		Immediata Causa (Final	CONCECTI	VE UEAR	RT FAILURE					ONE YEAR
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	pet _ tisu	Examiner		b		1				-	
	death certificate be axecuted e attanding physician and d for use as the burial-transit	Exa	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	ua to (or es a c	consequence of):				1	
68760,	sicia burd		Cause (Diseasa or injury that initiated avents	c							
68	rtificate ng phy s as the	edical	rasuiting in death) Last	Di	Je to (or es a c	onsequence of):				1	
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0	t the d	ys	Pert II. Other significant conditions co	ntributing to death but	not rasulting in	tha underrying ceuse g	IVan in Pert I.				the causs of death?
σ,	es that igned b	by P			_			10	Yes 2 No	3 Prop	ably 4 - Unknown
Records,	requires that een signed b hould be deta	D D						24a. Was	an autopsy	24b. We	ra sutopsy findings
00	_ D w	ete						parfo	rmed?	con	liable prior to applation of cause leath?
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of	는 무를		27. Menmer of Death	28a. Date of Injury	28b. T	ime of 28c. injury			how injury occurre		RESIDENCE
o	ding th. Afte	tio	Natural 5 ☐ Panding investigation	(Month, Day	rear) II		ork? ⊒Yas 2 ⊒No				
Division	Attending r death. sctor: After by the funs	fica	3 ☐ Suicida 6 ☐ Could not be	286. Piece of injury	y - At homa, fa	rm, street, fectory, office	•		Street end Numbe	r or Rural	Routa Number,
ă	afte Dire	Certification:	4 Homicida	building, atc.	(Specify)			City or Tov	vn, Stata)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral		29a. Certifiar 12 Certifying Phy	rsicien: To the best of	my knowledge	, deeth occurred et the	tima, date and plece,	end due to the	cause(s) and mar	ner as sta	ated.
	Ho Ho	edical	(Check only one) 2 Medical Exam	Inar: On the basis of each and menner state	xamination and	l/or invastigation, in my	opinion, death occur	rad at tha tima,	data and piace, a	nd dua to	the cause(s)
	To the within 2 To the comple	×	29b. Signature and titla of contifier	1//		29c. Licer	ned number		29d Pate signed	(Month, I	Jay, Year)
	12	+	Boylet to della	WM		NIO	420		160 20	190	0
			30, Name and addrass of person who p	omplated causa of dea	th (Item 23a) /	Type, Print)	0	- e	the Di	14.	7
	_	-	Throng Q Dallo	( M) 179	P14 2	=OOM AW	aug OL	164 M	1 208	137	
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	Registr	ar	IAN 0.9 200	DO Sener	~ /	9. Spork	2				

DHMH 16 Rav 6/95



#### Please Ty

If Under 1 Yaar

10f. Zip Code

Film Processor

Months

Days

1 ☐ Yas 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

pe or Print In Black Indelib	le Ink. Assure All Copies A	re Legible.	
State of Maryland / Departme Certifica	to of Dooth	ene 99	42546
	2. Data of Death Month Decembe	Day Year	3. Tima of Death 7:05am
reet and riumber)	4b. City, Town, or Location of Death	4c. County of Death	

ROCKVILLE

8. Data of Birth (Month, Day, Year) Mar. 15,1934

18. Mother's Nema (First, Middle, Maiden Sumama)

Nen T. Tran

19b. Meiling Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)

if Under 24 Hrs.

Hours

20877

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.)

MONTGOMERY

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: Asian

16b. Kind of Business/Industry

Micro Film

United States

9. Birthplaca (Stata or Foreign Country) South Vietnam

10d. toside City Limits

1⊠ Yas 2 No

**Physician** /Medical Examiner 1. Decedent's Nama (First, Middla, Last)

TAI T. NGUYEN

213-98-0782

10e. Street and Number

11 Marital Status

224 Lee Street

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Phuoc V. On

Tuat T. Pham

20a. Mathod of Disposition

17. Father's Name (First, Middle, Last)

19a. tnforment's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signatura of Funeral Service Licenses

10a. Stata

Director

Funeral

p

Completed

Be

Md.

Usual Residence of Decedent

4a Facility Nama (If not institution, giva str

10b. County

Montgomery

15. Decedent's Education (Specify only highest grade completed)

SHADY GROVE ADVENTIST HOSPITAL

1⊠M 2□F

7. Age (In vrs. last birthday)

10c. City, Town or Location

Gaithersburg

65

12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates:

College (1-4or 5+)

Funeral

Director

pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or herns 23a or 28a-f show any injury or other treumatic event, the Medical Exemples must be notified at DBS.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

physician and the burial-transit for use

10

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician/Medical Examiner Completed by Be Medical Certification: To

tmmediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medicat examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending invastigation 6 Could not be detarmined 3 Suicide 4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 31. Data filed (Month, Day, Year)

WAllask M.D 30. Name and address of person who completed causa of death (ttem 23a) (Type, Print)

JAN 0 3 2000

(Wife) 224 Lee St. Gaithersburg, Md. 20877 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.3 Metropolitan Crematory Alexandria, Va. 2000 22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntervel Between Onset and Death Opedio polverary failure

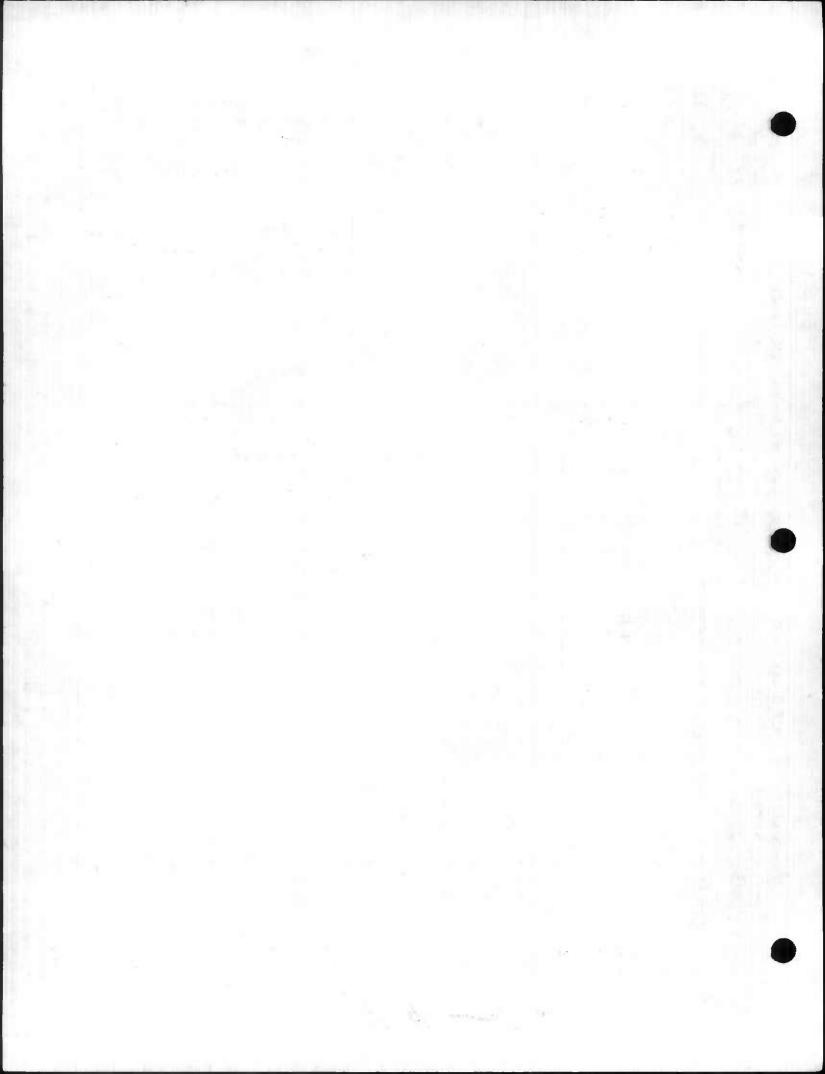
Due to (or es e consequence of):

(A. 6 kgol Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 1 Yes 2 No 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. tnjury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At homa, tarm, atreet, tactory, office building, atc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 53177 DOC 31, 1999. John WALLMARIC 9707 medicac Rockille, MD. Certa pring 32. Registrar's Signatura **ORIGINAL** 

**DHMH 16 Rev 6/95** 

State

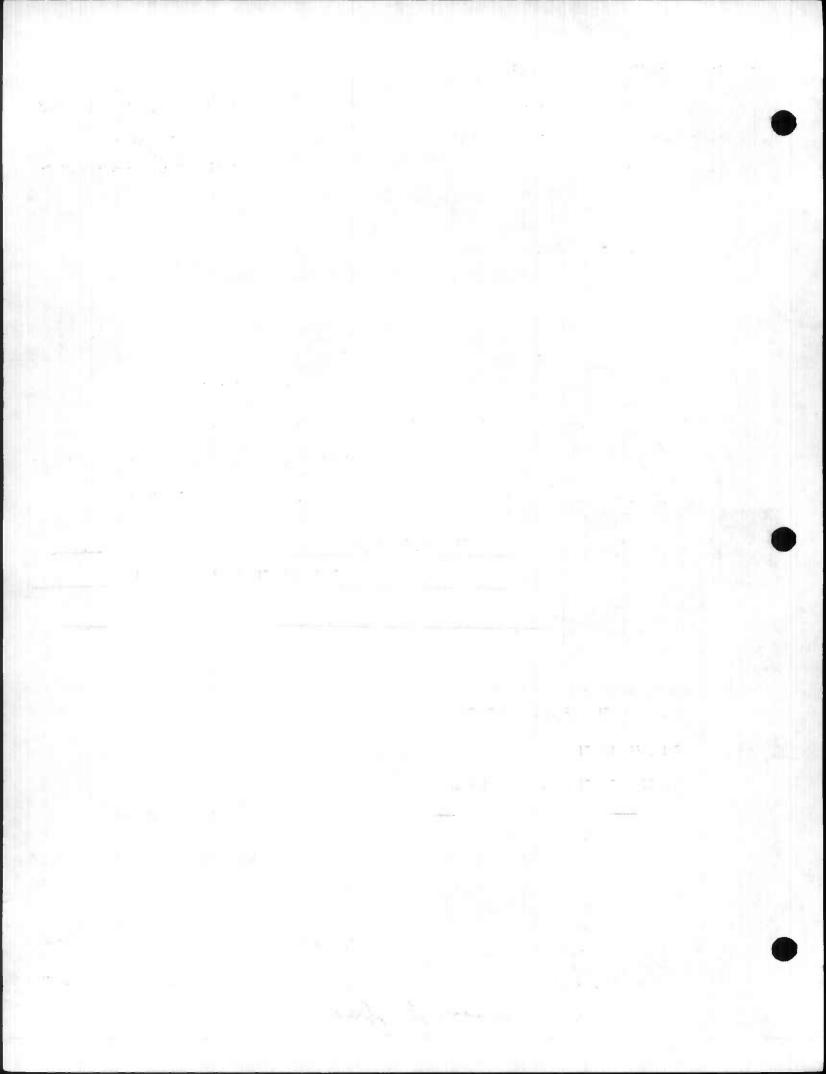
Registrar



State of Maryland / Department of Health and Mental Hygiene

Amended Item#23apt1&II,24b,25,26 perMEOG781 3/20/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** DECEMBER 30, 1999 11:23AM JOSEPH WALTER O'CONNOR /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY # Under 1 Year | # Under 24 Hrs. | 8. Dete of Birth Months | Days | Hours | Min. | MA (Month Dey, 1926) 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (Stete or Foreign **Funeral** 1 M 2 F MASSACHUSETTS 73 Yrs. 028-14-7314 Director Usual Residence of Decedent 10a State 10h Count 10c. City. Town or Location 10d. fnside City Limits 28a-f show MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 3428 KILKENNY STREET 20904 USA Nerne 23e Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indien. r than "natural", or flan Bleck, White, etc. NO Yes 2 No 1944
If Yes, Give
Yeer or Dates: 1946 1 Never Merried Merried Maryland 21215-0020 1 ☐ Yes 2 DANo Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT/ Elementary/Secondary (0-12) College (1-4or 5+) 4 AERO-SPACE ENGINEER NASA 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) 12 should be fi h and Mental H is marked off 36 JOHN F. O'CONNOR HELEN V. HEHIR 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Pages 1 and 2 s artment of Health an ortant: if them 27 is r ANGELA M. O'CONNOR (SPOUSE) 3428 KILKENNY ST. SILVER SPRING, MD 20904 Saltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Slata Pages sent of P 1 Burial 2 Cremetion 3 Removel from S 4 Donetion\_5 Other (Specify) VETERANS AT CROWNSVILLE1-5-2000 CROWNSVILLE, MARYLAND 21 Signature of Fungical Segrice Licens 22. Name end Address of FecilitYINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Onset and Deeth **Physician** CONGESTIVE HEART FAILURE
CONCESTIVE CARDIOMYOPATHY /Medical Immediate Cause (Final disease or condition resulting in death) YEARS Examiner Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examine ATRIAL FIBRILLATION MONTHS physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): Box 68760 YEARS OBSTRUCTIVE LUNG DISEASE certificate be Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): attending p Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 0 the signed by t ۵. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 X Unknown SMALL LACERATION OF SCALP DUE TO TERMINAL INJURY Records, by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy ATRIAL FIBRILLATION has 1 ☐ Yes 2 ♥ No 1 Tyes 200 No CHRONIC OBSTRUCTIVE PULMONARY DISEASE of Vital 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 X Yes -3 No 27. Menner of Death To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1X Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 🎦 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basia of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner steted. 29b. Signeture and other of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 3,2000 D 27837 TANUARY 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) LARCA LOUIS J. 7600 CARROCC AUE, TRKOMA PARK, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JAN 03 Registrar

**DHMH 16 Ray 6/95** 

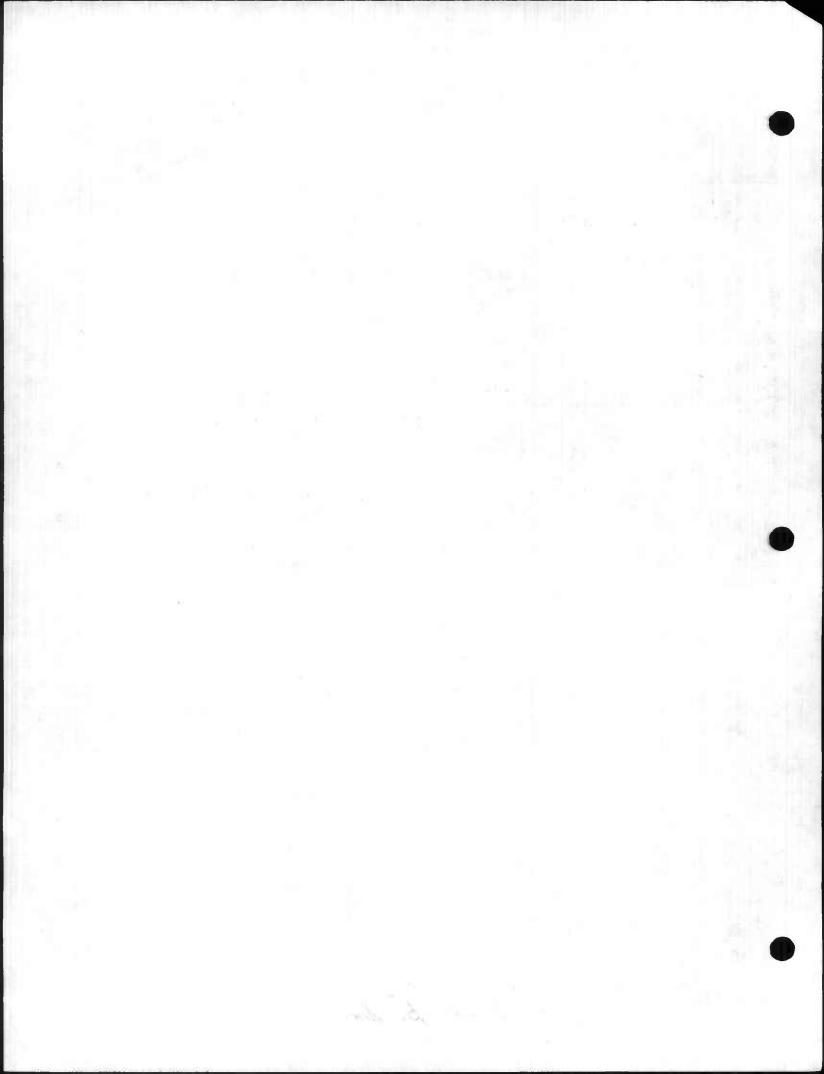


State of Maryland / Department of Health and Mental Hygiene

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						•		of Death		leg. No.	99	42548
	Di		ecedent's Neme (First, Middle, L.	est)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physician /Medical		JEAN	EVE	PA	ANEK				ER 29,		2:15 PM
	Examiner	4 - 5	acility Neme (If not institution, gi	ve street and numbe	r)			4b. City, Town, or				
	Examine		SHADY GROV	E ADVENT	TST F	IOSPIT	י א ד.	ROCKVI	TTD	MONTE	COME	D37
	Funeral	5. Sc				ast birthday)	If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Day	MONT		K.Y. lace (State or Foreign try)
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	or 28a-1 s be notified	Co	lorado El Pas	30	Col	lorado	Spring	S				1 ☐ Yes 2 ☐ No
4	22 2	10e.	Street and Number				10f. Zip Cod			10g. Citizen of \	What Coun	try?
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	r from 234	11. N	Meritei Stetus	12. Wes Deceder	t Ever in U,S	S. 13. W	as Decedent	of Hispanic Origin? (S Juban, Mexican, Puerl	pecify Yes or No-	14. Rac	e - America	
21215-0020	F	3	☐ Never Merried 2☐ Merried	Armed Forces 1 Yes 2 If Yes, Give Year or Detes	(No		Yes, specify C		o Hican, etc.)	Specify		olc. nite
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	Health sm 27 i			ughter	Jan. S.			r Oak Driv				20874
0	artment of Health prizert if Itam 27 Injury or other ti	20a.	Method of Disposition 1 ☐ Buriel / P ☐ Cremetion 3 [	Removel from Stet		ace of Dispos metery, crem	ition (Name of etory or other)		Dec 30,	20c. Location -	City or To	wn, State
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Baltimore,	Departr Departr Imports any Ink	21. 1	Signature of Fungrar Service Light	nsee		22.	Name and Ad	dress of Facility		ol Fune	ral H	lome
		100	They m.	Then		10	E. De	er Park Dr	ive, Ga	ithersb	irg,	MD 20877
		23a	Part1, Enter the disease, or con shock, or heart failure. List only	plicetions that cause	ed the death.	. Do not ente	r the mode of	dying, such as cardia	or respiratory ar	rest,		Approximate Interval Between
P	hysician		0									Onset and Death
4	/Medical		pediate Cause (Final passe or condition		T' F	ZPSI	<				1	
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	sed for	Pert	II. Other significant conditions	contributing to death	but not resul	iting in the un	derlying cause	given in Pert t.	23b. Did t	obacco use co	ntribute to	the cause of death?
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Vital Records,	been signed should be del		· · · · · · · · · · · · · · · · · · ·								1 24h W	autanus finalisas
0	cate has been s page 2 should								perfo	an autopsy med?	ava	ere autopsy findings allable prior to mpletion of cause
9	as b											death?
E	page 2								101	es 207No	10	Yes 2ENo
a	certificate rector, par	25. V	Wes case referred to medical					26. Place of Dec	ath (Check only o	ne)		
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	rithis and d		Menner of Death	28e. Dete of In		28b. Time of			28d. Describe h			7)
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	within 24 hours after de within 24 hours after de To the Funeral Direct completely filled in by it	29a.	Certifier (Check only one) Certifying P	hysician: To the bes relner: On the basis and manner:	of examination	rledge, death on and/or inve	occurred at the estigation, in m	e time, date and place ny opinion, death occu	e, and due to the oursed at the time,	cause(s) and medate end place,	enner as st and due to	ated. the cause(s)
4	within To the comple		Signeture and title of certifier				29c. Lic	ense number		29d. Date signe	d (Month.	Day, Year)
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	6		- Muu	W.	-		Et	51280	1	<i>jecemi</i>	per a	29,1999
		30. N	leme and address of person who	completed cause of	death (Item	23a) (Type, P	rint)					
		An	ushiravan Dadga	ar, M.D.,	13219	Execut	tive Pa	rk Terrace	, German	ntown, 1	1D 2	0874
	State	31. 0	Dete tiled (Month, Dey, Year)		trar's Signati	ure /						
	Registrar		TAN 03 25	100 Arm	مصم	B.	Spark	2				

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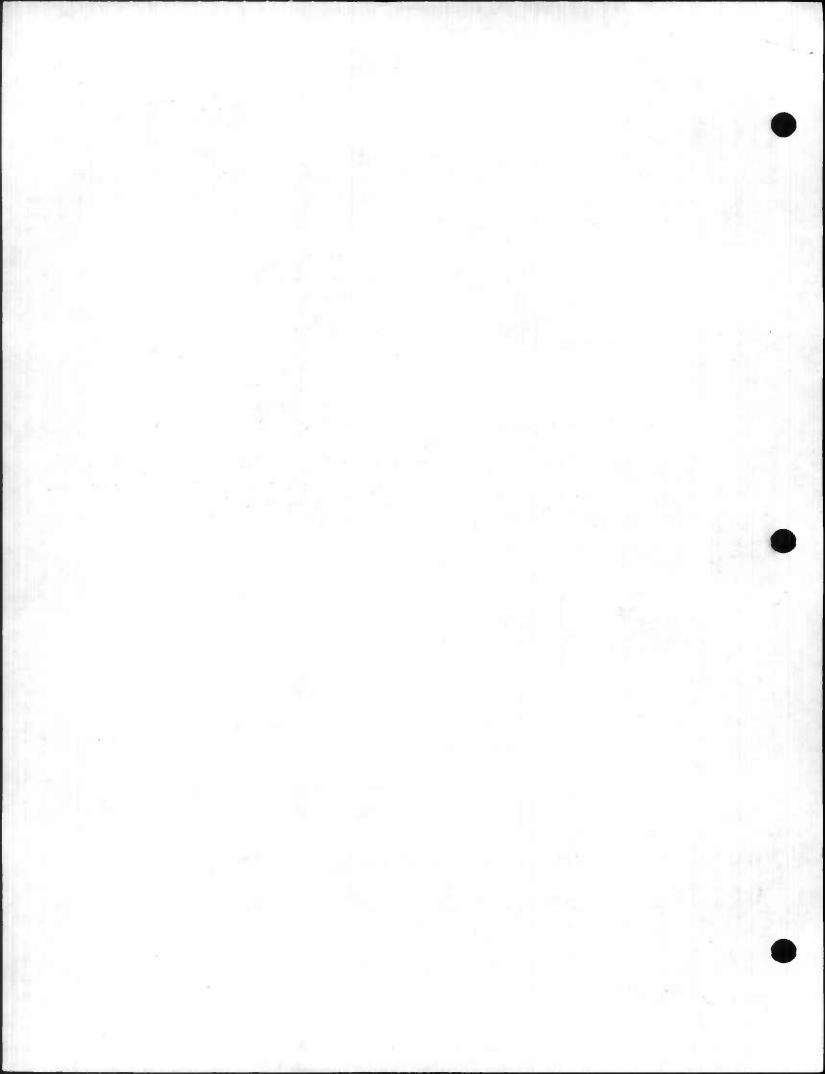
Certificate of Death Reg. No.		1 600 0 7 2
tate of Maryland / Department of Health and Mental Hygiene	99	12549
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		est)					2. Data of De Month		3. Tima	ot Death									
Ruth	]	Kirk	Row	bothan	1		Dec. 2	8, 1999	6:00	AM									
4a Facility Nama (If	not institution, giv	ve street and numb	per)			4b. City, Town, or I	Location of Deat	th 4c. County	y of Death										
Haven Hom					W Haday 4 Vans	Potomac If Under 24 Hrs.	T		ntgomery										
5. Social Security Nu		Sex 7. 1 □ M 2 K F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		8. Data of Bir (Month, Da	ay, Year)	Birthplace (State Country)	or Foraign									
160-09-81 Usual Residence of			89				Mar. 1	9, 1910	New York										
10a. Stata	10b. County		10c. City	, Town or Lo	cation				10d. Inside	City Limits									
Md.	Montgom	ery	Po	tomac					1 □ Ye	s 2/1 No									
10e. Street and Num	ber				10f. Zip Code			10g. Citizen of	What Country?										
11834 Go	ya Dri				208	354		U.S.	A										
11. Marital Status		12. Was Decede Armed Force 1 Yes 24 If Yes, Give Year or Date	ent Ever in U,S	S. 13. V	Was Decedent of I Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puart	pecify Yas or No o Rican, atc.)	0- 14. Rad	ce - Amarican Indian, ick, Whita, atc.										
1 Never Marrie	0	1 Tes 24	No No		I □ Yas 2 No		The state of		White										
3XX Widowed 4			96:		factle Havel Ocean														
(Specif	15. Decedent's E fy only highest gr	ade completed)		(Give	kind of work done  OO NOT use retire	pation during most of wor ed)	king	100. KING OF B	lusinass/Industry										
Elementary/Secon	dary (0-12)	College (1-4	lor 5+)	Homem				At Hor	me										
17. Father's Name (F	First, Middle, Last	1)				18. Mother's Nan	na (First, Middla												
Frank K	irk					Florence	e Longo												
19a. Informant's Nar	me/Relationship	(Type, Print)		19b. Mailir	g Address (Stree	t and Number or Ru	ıral Route Numb	er, City or Town,	, State, Zip Code)										
Sarah B.		ughter																	
20a. Method of Dispo		Removal from Sta	ata 20b. Pl	ace of Dispo emetary, cren	sition (Nama of natory or other pla	ace)	Data	20c. Location	- City or Town, Stata										
4 Donation	5 ☐ Other (Special	fy)					/3/2000												
21. Signature of Fun	Arlington National 1/3/2000 Arlington, VA  Signature of Funeral Service Licensee  Joseph Gawler's Sons INC, 5130 Wisconsin Ave.  NW, Washington, DC 20016																		
23a Part Enter the shock, or heart	e/disease, or com	nplications that cau	sed the death					arrast,	Approxim	ata									
		one cause on eac	an iin <del>e</del> .						Intarval B Onset and										
disease or condition	W 1021	a. ARRE	AIMHTY				Immediate Cause (Final disease or condition ARRHYTHMT A												
disease or condition resulting in death)  ARRHYTHMIA  Due to (or as a consequence of):																			
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Sequentially list conif any, leading to immany, leading to immany. Enter Under Cause (Disease or in that initiated events resulting in death) Li  Part II. Other algnific  25. Was case refarra axaminer? 1   Yas   22   Neural   2   Accident   3   Suicide   4   Homicide  29a. Certifier (Check only one)	eart conditions of the conditi	Hospital: 1 Inp  28a. Date of Inp  (Month,  28a. Place of building,  hysician: To the beniner: On the business and manner  completed cause of	Due to (or  Due to (or  Due to (or  Due to (or  Injury and the property of examination of examination of death (Item)	as a consequence as a c	uence of):  uence of):  t 3 DOA Of 28c. Inju.  M 1 eet, factory, office  occurred at the trestigation, in my  29c. Licen	26. Place of Destriber:  AN Nursing Hary at ok?  Yes 2 No  ime, date end place opinion, death occurse number	24e. Wes perfect the second of	Yes 2 No sen eutopsy ormed?  Yas 2 No ona) idence 6 Oth how injury occur (Street and Numl wm, Stata) cause(s) and medate and piece, 29d. Date signe	3 Probably 4  24b. Were autops available prio completion of death?  1 Yas 2  har (Specify)  med  ber or Rural Routa Number or Rural Routa Number of Rural	Unknow  y tindings y to to cause  No									

State Registrar

JAN 0 6 2000

b. Sports 32. Registrar's Signatura

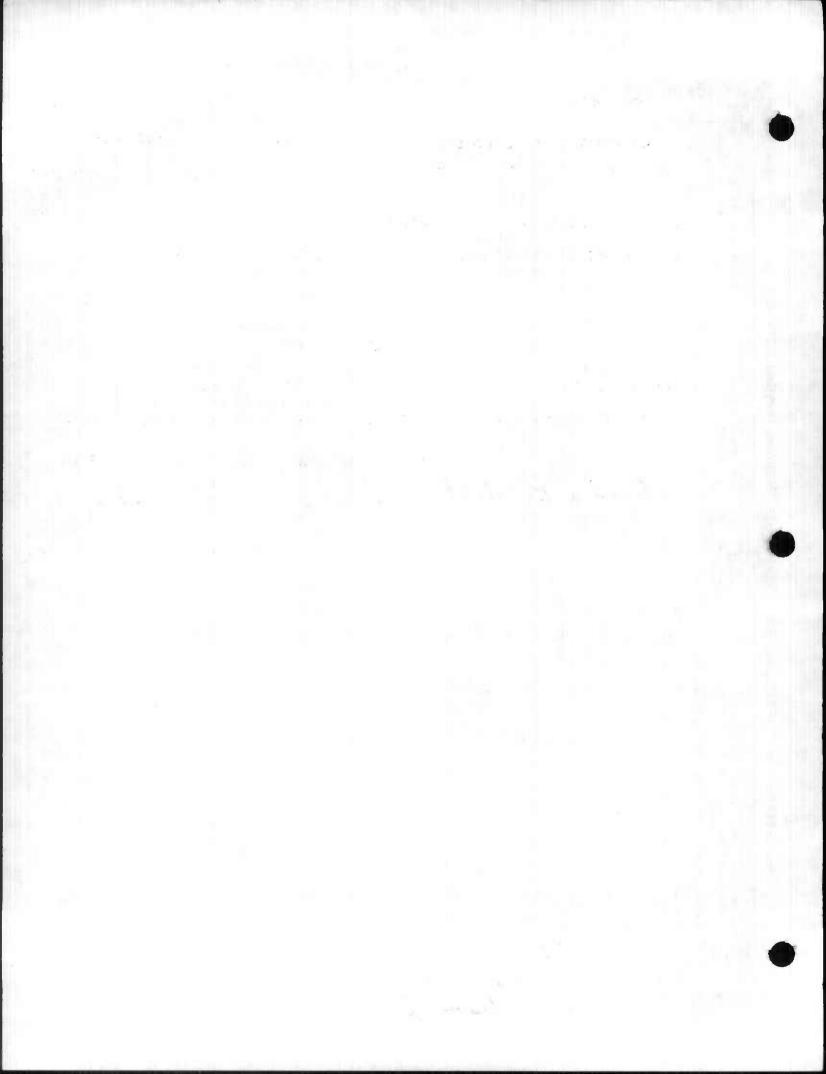


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Na	me (First, Middle, L			•	tificate of	Death	2. Date of Dea	eg. No. 9	3. Time of Death
	Physician	GLORI	A ROTTER						12.31.9	99 Day	3:40 AM
	/Medical Examiner	4a Facility Name	(If not institution, g	ive street and numb	oer)			4b. City, Town, or I	ocation of Death	4c. County	of Death
				NTERAL HO			K ( lada 4 Vasa	OLNEY			GOMERY
	Funeral Director	5. Social Security 130.22.3 Usual Residence	3194	Sex 1□M XXF 7.	Age (In yrs.	lest birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 04.02.1		9. Birthplace (State or Foreign Country) NEW YORK
	Mand Mand	10a. State	10b. County		10c. Cit	y, Town or Lo	cation			1 1	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show from the notified an neral Director	MD	MONTGO	MERY	SI	LVER S	PRING				1 ☐ Yes ♣♠No
	or 28s-fa	10e. Street and N			T.O.O.		10f. Zip Code		1	Og. Citizen of V	What Country?
	r items 23a	15101 IN		N DRIVE #	ent Ever in U	S. 13. V		20906 Hispanic Origin? (S	pecify Yes or No-	USA 14. Rac	e - Americen Indian,
5-0020	urs after	1 Never Ma	rried 2 Married	Armed Forc	es? ∭No		Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)	Specify	ck, White, etc.  WHITE
5-0	"natural",	(Sp.	15. Decedent'a	Education rade completed)		16a. Deced	lent's Usuai Occu kind of work done	pation during most of wor ed)	king	16b. Kind of Business/Industry	
2121	y withir than than omp	Elementary/Seg	- 2	Coilege (1-4	or 5+)		ARCH ASS	SISANT		PHYSIC	
Maryland	Mental H Mental H arked out artic ever	IRVING I	IPANSKY	51)			5.4	MINNIE	FEINSTE	IN	
Mar	d 2 sho		Name/Relationship			100	The state of the s	t and Number or Ru			
re,	es 1 an of Heal itam 2 r other	20a. Method of Di	sposition			Piace of Dispo	sition (Name of natory or other pla				City or Town, State
imo	Page nent o ant: If ury or		2 ☐ Cremation 3 5 ☐ Other (Spec	☐Removal from St	ate		BANON CE		01.02.00	ADELPH	I, MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Important: If itsm 27 any injury or other ti QDCS.	21. Signature of I	Funeral Service Lic	Riverb	ursh	E			RAL DIREX	CTION,	INC.
	Physician /Medical	23a. Part1. Enter shock, or he immediate Cause disease or condit	e (Finai			h. Do not ent	er the mode of dy	ing, such as cerdiad	or respiratory art	rest,	Approximate Interval Between Onset and Deeth
1	Examiner	resulting in death	)	a		or as a conseq					
	d ansit	Convention lies a		b	Due to /o	or as a conseq	uence of):				on the second se
0,	i be executed sician and burial-transit	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated ever	immediate derlying		Dug 10 (c	as a conseq	uerioe orj.				1
x 68760,	g physas the	that initiated ever resulting in death	of injury hts ) Last	c	Due to (o	r as a conseq	uence of):				
Box	death cert e attending d for use ician/M										
P.O.	d by the etached	The second second	officant conditions	contributing to deal	th but not res	ulting in the u	nderlying cause g	iven in Part t.		obacco usa co /es 2 0 No	ntribute to the ceuse of death?  3 Probably 4 Unknown
Vital Records,	The law requires the cate has been signed page 2 should be d								24a. Was a perfor		24b. Were eutopsy findings available prior to completion of cause of death?
R	reician: The law scerificate has b director, page 2 s director, page 2 s o Be Comple								1 🗆 Y	es 2/1 No	1 ☐ Yes 2 ☐ No
/ita	ysician: is certifica director,	25. Was case reference?	erred to medical						ath (Check only or	ne)	
of	£ 55 -	1 ☐ Yes 2 €		Hospital: 120 Ing	-	ER/Outpatier	I 3LI DOA		lome 5 Resid		
On	th. : After s fune	1 Naturai	5 Pending	(Month,	Dey Year)	Injury	Wo		200. 0000110011	own nary occur	
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	3 Suicide	2 Accident investigation M 1 Yes 2 No								ber or Rurel Route Number,
	Hospita     124 hours     Funeral     Idetely fille	29a. Certifier (Check only one)	1 Certifying F 2 Madical Ex	Physician: To the basaminer: On the basand manne	is of examina	wiedge, death tion and/or in	occurred at the trestigation, in my	ime, date and piace opinion, death occu	, and due to the d irred at the time, d	ause(s) and madate and piaca,	anner as stated. and due to the cause(s)
	To the comp	29b. Signature ar	nd title of certifier	0			29c. Licen	ise number	1365	29d. Date signe	od (Month, Day, Year)
	15	Cl	lika fy	your	M.D.		MAKY	LNO 04	452	UE CEMPS	SER 31, 1999
	•	30. Name and ad	dress of person who	o completed cause	of death (Item	n 23a) (Type, 4327	Print) DR	CHITPO	RATI KY CAND	4 GOPAL 2093.	-, M·D.
		Od Date Glad (Mr.	nath Davi Variati	20 Dt	Introduce Oliver						

Registrar

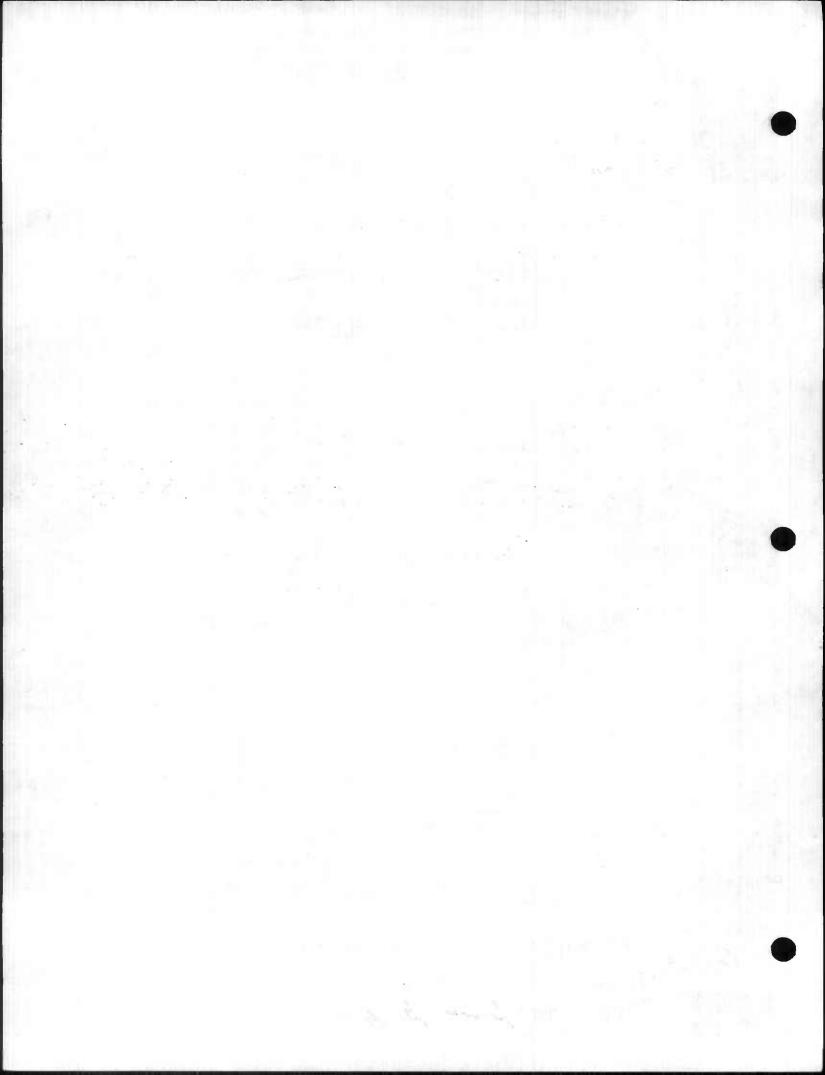
JAN 03 2000 32. Pogistrar's Signature G. Apacks



State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of Death		Reg. No.	9 12551	
		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Dev Year 3. Time of Death		
	Physician								
	/Medical Examiner	4a Facility Name (If not institution, give str			4b. City, To	wn, or Location of Deal			
	LXammer	15100 Interlachen	Dr. #807		Silve	r Spring	Montgo	ome rv	
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.		r 1 Year   If Under:	24 Hrs. 8. Date of Bi	rth	Birthplace (State or Foreign Country)	
	Tatural, or tems 23e or 28e4 show of the Maryland and the Examiner must be notified and leted by Funeral Director	054-03-6001	M 2 <b>I</b> Ø F 82	Yrs. Months	Days Hours	Min. (Month, Di Apr. 28		Poland	
		10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits	
		MD Montgomer	y Sil	lver Spring				1X Yes 2 □ No	
		10e. Street and Number		10f. Zi	Code		10g. Citizen of W	That Country?	
		15100 Interlachen	Dr. #807		20906		U.S.	.A.	
20		11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		dent of Hispanic Ori city Cuban, Mexican 2 No Specity:	gin? (Specify Yes or No , Puerto Rican, etc.)	5- 14. Race Blac Specify	a - American Indian, k, White, etc.  White	
00		15. Decedent's Educa	22,000				16b. Kind of Business/Industry		
21215-0020		(Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			Education		
12	filed within Hygiene. other than ent, me Me	Elementary/Secondary (0-12)	School Teacher						
	be filed d other event, n	17. Father's Name (First, Middle, Last)	5+	3CHOO1		r's Neme (First, Middle			
Maryland	0 - 0								
3	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if them 27 is marked other any injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury or other traumatic event, and injury events and events and injury events and injury events and events	Ernest Repps  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address				Rose Blatt Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Ma									
e,	thealt	Irving J. Rotkin/						Spring, MD 20906	
Baltimore,	ment of he was a way or or	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Mt. Lebanon Cemetery  Adelphi, Maryland							
Bal	Departition Departition Departition Department Departme	21. Signature of Funeral Service Licensee		Danzan	sky-Goldb	y erg Memoria Pike, Rocky	al Chapel	ls, Inc.	
		23a. Part1. Enter the disease, or complica shock, or heert feilure. List only one	tions that caused the deat					Approximate Intervat Between	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  ATRIAL PUBRILLATION  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or Injury)  Cause (Disease or Injury)							
Box 68760,	The law requires that the death certificate be executed has been signed by the attending physician and page 2 should be detached for use as the burisi-francompleted by Physician/Medical Examp	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d							
. E		Part II. Other algoifficant conditions contri	ulting in the underlying	cause given in Pert I.	. 23b. Did	23b. Did tobacco use contribute to the cause of death?			
P.0			1			Yes 2 No 3 Probably 4 Unknown			
Vital Records,						24a. Was	an autopsy ormed?	24b. Were autopsy tindings available prior to completion of cause of death?	
-						10	Yes 20 No	1 ☐ Yas 2 ☐ No	
Ita	Be G	25. Was cese referred to medical 26. Place of Death (Check only one)							
Division of V	hysic his o al din To	examiner?  1 Yes 2 No  27. Wenner of Death  18 Netural 5 Pending 2 Accident investigation	Hospital: 1   Inpatient 2   ER/Outpetient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    28a. Date of Injury (Month, Day Year)   28b. Time of Injury at Work?   1   Yes 2   No   No   Nursing Home 5   Residence 6   Other (Specify)    28d. Describe how injury occurred   Nursing Home 5   Residence 6   Other (Specify)    28d. Describe how injury occurred   Nursing Home 5   Residence 6   Other (Specify)    28d. Describe how injury occurred   Nursing Home 5   N						
Divis	tal or Attending P is after death. In Director: After ed in by the tunen Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				8f. Location (Street and Number or Rural Route Number, City or Town, State)		
	the Hospital hin 24 hours at the Funeral it mpletely filled Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.							
	M M	29b. Signature and Date signed (Month, Day, Year)						(Month, Day, Year)	
	/	Henry 1	Chare.	(W) 1	71444	0	12130	77	
	/	/ / //	- Crudy o		116				
	13	30 Name and address of person who com	pleted cause of death (Item	n 23a) (Type, Print) ) ///61 New	HAMSH	ke Avenu-	e Silver S	prine	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

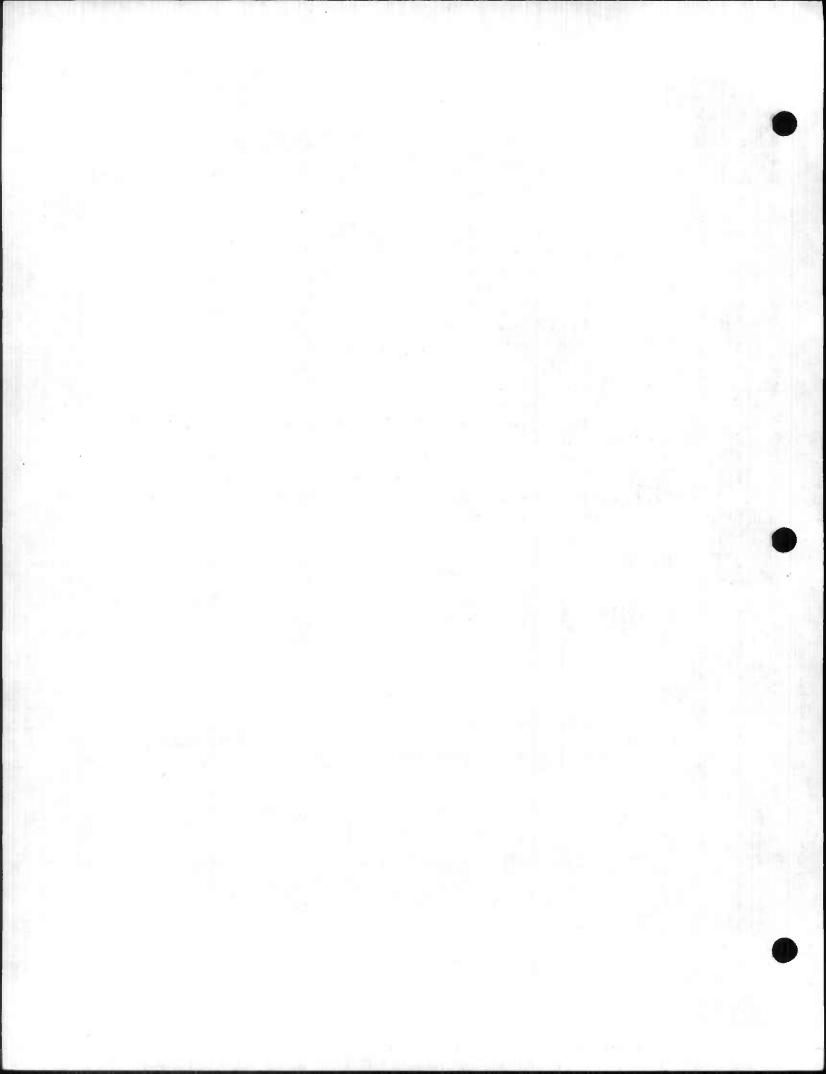
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Roya1 Edwin Rostenbach 22 8:20 P.M. Dec. 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Bethesda Bethesda Montgomery Hours Min. 8. Dete of Birth (Month, Day, Year)
Sept. 20, 1912 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 18 M 2□ F 87 Yrs. 406-12-7496 Director Iowa Usual Residence of Decedent 10a. Stete 10b. County worle 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 26a-f shore the Medical Examiner must be notified at MD Bethesda Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6111 Wiscasset Road 20816 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Raca - American Indien, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours efter 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Chemical, Environment Elementery/Secondary (0-12) College (1-4or 5+) & Energetic Engineering + Chemical Engineer other 1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked other eny Injury or other treumatic event place. 17 Father's Name (First Middle Last) 18 Mother's Neme (First Middle Maiden Sumeme) Be Robert Rostenbach Ivah Thoene 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5597 Seminary Road Burton Bridgens - Bro.-in-law Falls Church, Virginia 22041 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 1/8/2000 Buffalo, 4 ☐ Donation 5 ☐ Other (Specify) Buffalo Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Hombaker homas E. 5130 WI Ave. N.W. 20016 Washington, D. C. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Thythma /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) physician and the burief-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of): ettending 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 28 No 1 Yes 3 □ Probably 4 □ Unknown signed b Records, þ 24b. Were autopsy lindings aveileble prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed Deed hes 2 000 1 Yes 1 □ Yes 2 □ No of Vital Be 25. Was case referred to medical 26. Placa of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division Affer Attending 1 Matural 5 Pending deeth. 1 TYes 2 No investigetion 2 Accident Funeral Director: tely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) or All 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated. edicai 29a. Certifie 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner steted. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D42518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, Md. , 11119 Rockville Pike #316, Rockville, Md. 20852 31. Dete filed (Month, Day, Year) 32. Realstrer's Signeture State oouts JAN 05 2000 Registrar

DHMH 16 Rev 6/95

CHABLAN

ROYAL

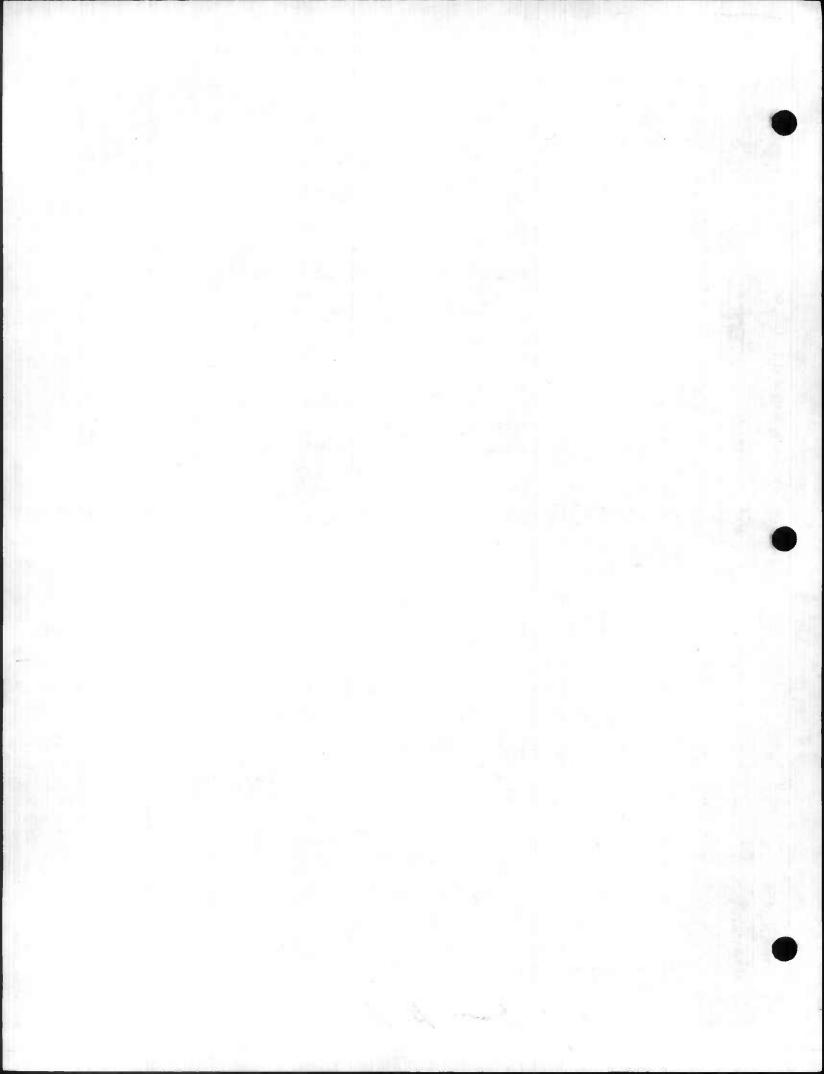
SOSTEN BACH



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg.	No. 33 42333							
1. Decedent's Name (First, Middle, Last)  2. Date of Death Month	Day O'Sar 720 PN							
/Medical ROSE SUSSICIND 12 3	0 99 /2011							
Examiner  4a Facility Nama (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death							
Manorcare Bethesda Bethesda Bethesda  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Montgomery							
Funeral Director  5. Social Security Number  083-18-8930  6. Sex 1 Months Days Hours Min.  1 M 2 N F  97  1 Months Days Hours Min.  1 Jan. 15,	9. Birthplace (Stata or Foraign Country) Poland							
30a Chata 10h County 10a Chy Trum or Leasting	10d. Inside City Limits							
10a. Stata 10b. County 10c. City, Town or Location  MD Montgomery Bethesda	1∭ Yas 2□ No							
MD Montgomery Bethesda  10e. Street and Number 10f. Zip Code 10g.	Citizen of What Country?							
6530 Democracy Blvd. 20817	U.S.A.							
6530 Democracy Blvd.   20817	14. Race - American Indian, Black, Whita, atc.							
3 ☑ Widowed 4 □ Divorced If Yas, Giva 1 □ Yes 2 ☑ No Specify:	Specify: White							
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working tiffa. DO NOT use retired)	. Kind of Bustnass/Industry							
15. Decedent's Education (Specify only highest grade completed)  Elamantary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker	Dam Home							
	Own Home							
17. Fathar's Nama (First, Middla, Last)  Anselm (Anschel) Kris  19a. Informant's Name/Ratationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Routa Number, Call Name (Street and Number)  19b. Mailing Address (Street and Number or Rural Routa Number, Call Name (Street and Number)  19b. Mailing Address (Street and Number or Rural Routa Number, Call Name (Street and Number)	on Jumamay							
19a. Informant's Name/Ratationship (Type, Print)  19b. Mailing Address (Street and Number or Rurat Routa Number, Co	v or Town, Stata, Zio Code)							
Limitar Chookind/ Eranddaughter   5/5 West the AVE New York, Ne								
Emily Susskind/ Granddaughter   525 West End Ave., New York, New Y	Location - City or Town, Stata							
4 Donation 5 Other (Specify) Mt. Moriah Cemetery 2000 Fa:								
21. Signature of Funeral Sarvice Licensee  22. Nama and Addrass of Facility Danzansky-Goldberg Memorial ( 1170 Rockville Pike, Rockville	Chapels, Inc.							
23a. Part Earer the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Intervat Batween							
Physician /Medical Examiner Immediata Causa (Finat disease or condition rasulting in death)  The physician Immediata Causa (Finat disease or condition rasulting in death)  The physician Immediata Causa (Finat disease or condition rasulting in death)  The physician Immediata Causa (Finat disease or condition rasulting in death)  The physician Immediata Causa (Finat disease or condition rasulting in death)  The physician Immediata Causa (Finat disease or condition rasulting in death)	Onset and Death							
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
Causa. Enter Underlying Causa. Enter Underlying	if any, laading to immadiate causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last  Due to (or as a consequence of):							
Cause (Disease or Injury that initiated evants rasulting in death) Last  Due to (or as a consequence of):								
d ding ding ding ding ding ding ding din	d.							
XO So of the sea of th	t							
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes	23b. Did tobacco use contribute to the cause of death?							
ARKINSONS DISEASE	1 Yes 2 No 3 Probably 4 Unknown							
DEMENTIA 24a. Was an a performed								
2	2 No 1 Yas 2 No							
	25. Was casa ratarred to medical 26. Place of Death (Check only one)							
Axaminary    Axaminary   Axaminary   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   Axaminary   Other:   Axaminary   Other:   Axaminary   Other:   Axaminary   Other:   Axaminary   Other:   Axaminary   Other:    axaminar/ Hospital: Other /								
25. Was case ratarred to medical axaminar?    25. Was case ratarred to medical axaminar?   26. Place of Death (Check only ona)   26. Place of Death (Check only ona)   27. Mannar of Death   28a. Deta of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?								
2 Accident Invastigation M 1 Yas 2 No  2 Sold Sold Sold Sold Sold No. 2 Sold No. 2 Sold N	and Number or Dunt David Number							
28a. Data of Injury (Month, Day Year)  28b. Time of Injury at Work?  28d. Describe how learning invastigation  28d. Describe how learning invastigation  3 Suicide  4 Homicide  28d. Describe how learning invastigation  28d. Describe how lear	28i. Location (Street and Number or Rurat Routa Number, City or Town, Stata)							
29a. Cartiflar 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause	29a. Cartifiar  12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.							
29a. Cartiflar (Check only one)  29a. Cartiflar (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s)							
29b. Signatura and titla of certifiar 29c. License number 29d.	Data signed (Month, Day, Year)							
32 Malya Cemory Mas DSS/11	Muly lemmy ms D35791 12/31/99							
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)	MD 20902							
IN VEMURY 9801 GEORGIA AVE SILVER SPRING	1.00000							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999 Year Month PARKER ALAN STENNETT 28 12:47 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Sacurity Number If Under 1 Yaar | If Undar 24 Hrs. 6 Sax 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) **Funeral ₩** 2□ F Days Yrs. Director MARYLAND DEC 28 1999 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examiner mate to notified at 10d. Inside City Limits 1 Yas 2 No Director Loudoun Middleburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Box 1535 20118 USA deeth 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes 22 JWo If Yes, Give Year or Dates: 11. Marital Status Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes ŽÍNo Specify: Š Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none Peges 1 and 2 should be filed value and Mental Hygie term. If Item 27 is marked other t 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Brett Alan Stennett Kristen Page Draisey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) Kristen P. Stennett - Mother Box 1535 Middleburg, Virginia other 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) Middleburg Memorial Cem 12/31/99 Middleburg, VA 21. Signature of Funeral Service License 22. Name and Addrass of Facility Metropolitan Funeral Service. Inc. 5517 Vine Street Alexandria, Virginia 22310 . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, k, or heart failura. List only one cause on each line. Approximata Interval Batw Onset and Death Physician /Medical Immediate Cause (Final EXTREME PREMATURITY diseasa or condition rasulting in death) Examiner Due to (or as a consequenca of) Examiner physiclan end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Dua to (or as a consaquance of) 88 ed by the attending detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 | Yes 2 No 3 | Probably 4 | Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 X Yes 2 □ No 1 ☐ Yas 2 ☒ No Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifice Be 25. Was case ratarred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Dascribe how injury occurred 5 Panding Investigation 1 XNatural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) B 4 - Homicide filled in 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) DEC 30 1999 RES-000 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 JEROME V. PONDER, CAPT, MC, USA 31. Date filed (Month, Day, Year)

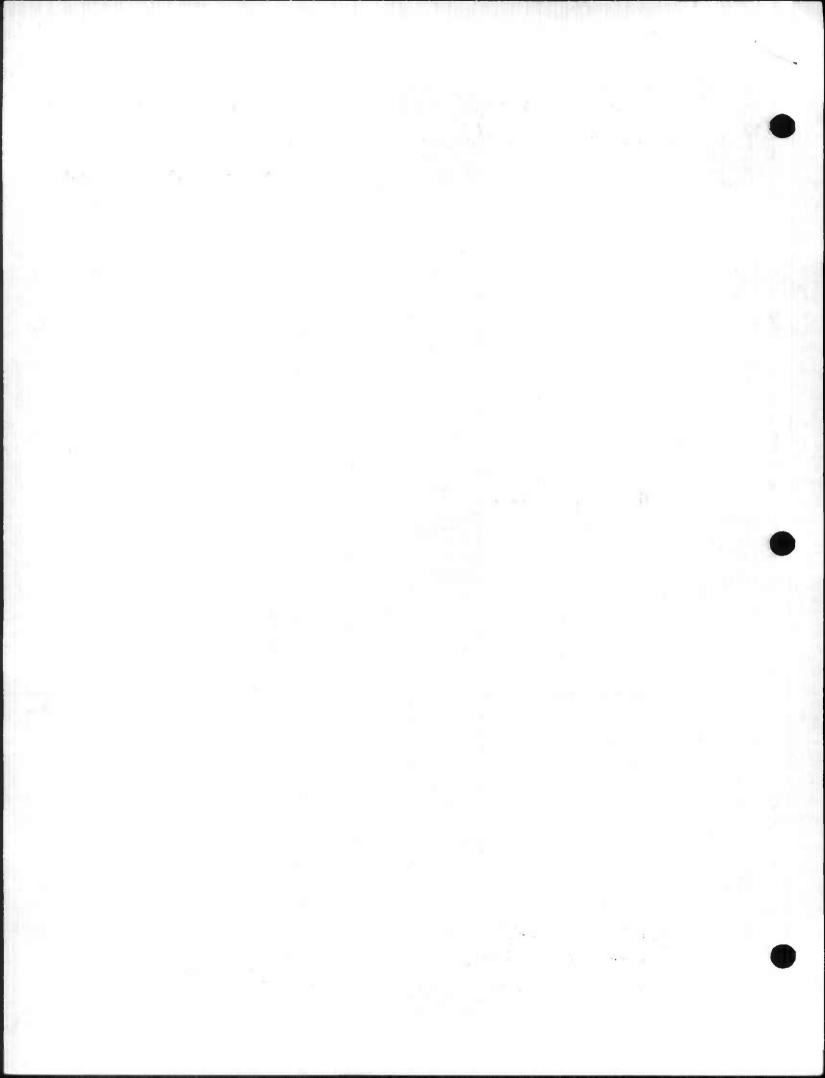
32. Registrar's Signature

Merca

State

Registrar

**JAN 06** 



Richard Steiner AMEND ITEMS: #23 PART I,

27, 28A-F1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1	Physici /Medic Examin	al
	Funeral Director	

filed within 72 hours after death Baltimore, Maryland 21215-0020 II Hygir Ould be f marked 1 and 2 Health Nam 27 Pages 1

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. signed by t Division of Vital Records. page 2 should Aftar this

Reg. No. 1. Decedenl's Name (First, Middle, Last) 3. Time of Death 2. Date of Death December 1999 8:20 A.M. Richard Steiner 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8301 Wisconsin Avenue Bethesda Montgamery If Under 1 Yeer 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Months Days Hours Min. 1☑ M 2□ F Yrs. 456-21-3992 44 3, 1955 Mexico Usual Residence of Decedent 10a. Stale 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or flame 23s or 25s-f show iene. Than "natural", or itema 23a or 28a-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Bethesda Montgomery 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 5315 Wehawken Road 20816 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ Mexican 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) O'Donnells Chef 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Malcolm Steiner Altagracia Landeros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Wehawken Road Bethesda, MD 20816 Henry M. Steiner/Father 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremelion 3 ☐ Removal from State 28804, Metropolitan Crematory 4 ☐ Donellon 5 ☐ Other (Specify) Alex., Virginia Funeral Home 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Wisconsin Ave. Washington, D.C. 20007 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final NARCOTIC INTOXICATION disease or condition resulting in deeth) **Examiner** Due to (or as a consequence ot). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? Yes 2 No Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) at scene 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury
28b. Time of A
FOUND:
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1
28b. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
UNKNOWN 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? ending investigetion 1 Natural UNKNOWN 1 Yes 2 No ours after death. death. 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number City or Town, State) 8 3 0 1 WISCONSIN AVE. SILVER SPRING, MD 4 T Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier O.C.M.E. January 01, 2000

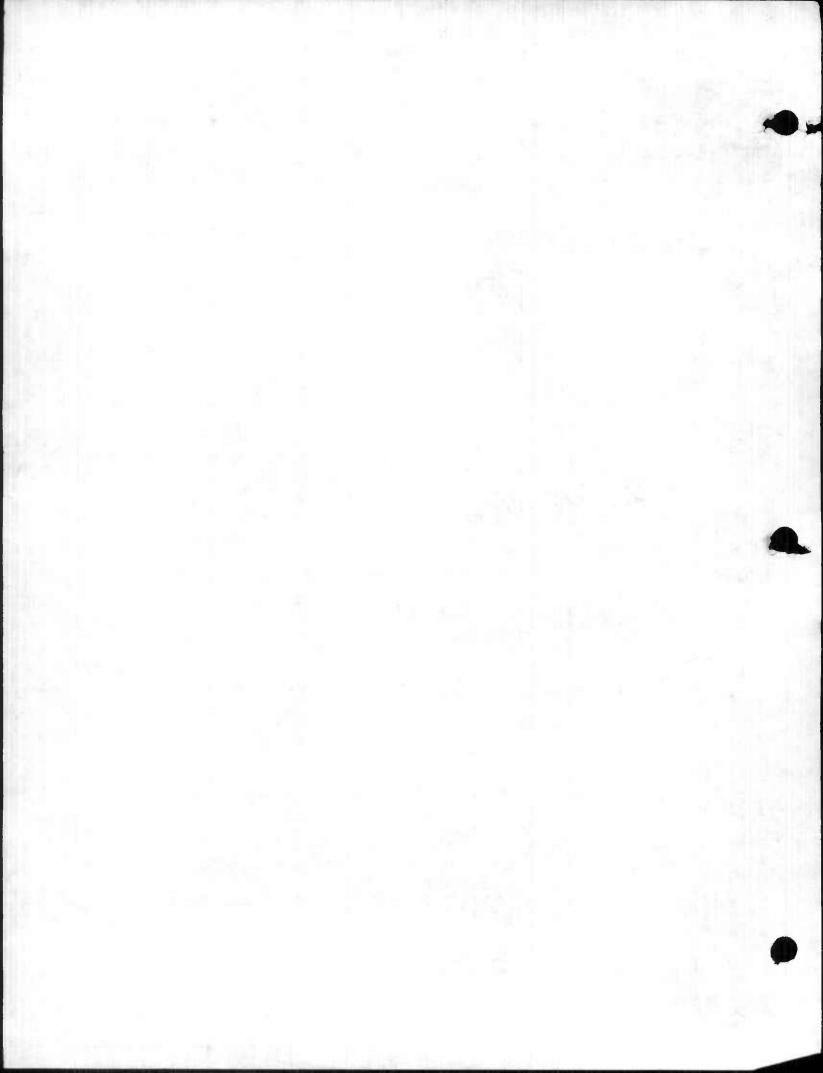
State Registrar

David 31. Date tiled (Month, Day, Year) JAN 05 2000

rowle 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** Udom Srivarin December 30, 1999 0224 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 70 Director none May 25, 1929 Thailand Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location worls ! 10d Inside City Limits r 28a-f show .notified at 1 Yes 2 No Director Thailand Bangkok N/A 86 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be Berns 23a 4/36 Tawanna Village, Phahonyathin Rd. 23 10900 Thailand Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: Asian by 3 ☐ Widowed 4 ☐ Divorced i Hygiene. i Hygiene. other then \*natum ent, the Medical J Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Chief Editor 4 Newspaper permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygi-Important: if Item 27 is marked other any Injury or other traumatic event, 23 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Yongkim Srivalin Thongsuk Xiao 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hsu/Son-in-Law 2529 Lindley Terrace, Rockville, Maryland 20850 Dec. 31, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 1999 Bethesda, Maryland 21. Signature of Funeral Service Line 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-20850 MO1126 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Rupture of Myocardium Minutes Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction Minutes ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 950 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 6 8 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: funeral director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 X ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After t 28c. Injury at Work? Division Attending 5 Pending investigation 1 (XNatural Injury 1 ☐ Yes 2 ☐ No deeth. 2 Accident the within 24 hours after deet To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 6 the Hospital Testifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

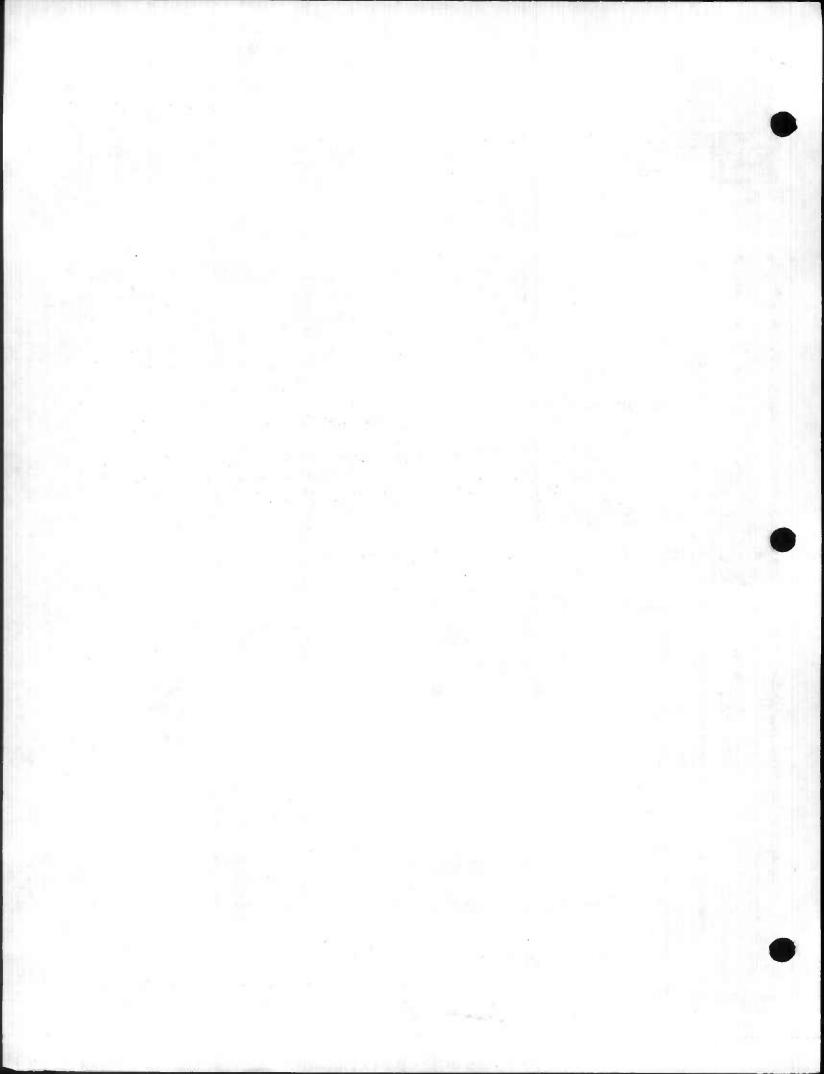
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who confideted cause of death (Item 23a) (Type, Print) 9901 medical Center Dr., Rockwille, mp. 20850 Sherr m.D., 9901 32. Registrar's Signature Debo ( She State

**DHMH 16 Rev 6/95** 

Registrar

JAN 03

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2340 **Physician** DAULO E. SOLOMONSON OKCEMBER 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPOTING HOUT CROSS HOSPITA Martonkin If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F Months Days Hours 219-42-4375 Yrs. OHIO **Director** 56 4-15-1943 Usual Residence of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Masseal Examinar must be notified at Yes 2 No Director SILVER SPRING MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10319 INSLEY ST. 20902 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 22000
If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours efter 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) al Hygiene. College (1-4or 5+) Elemantary/Secondary (0-12) ADVERTISING 4 GRAPHIC DESIGNER 18. Mother's Nama (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) h and Mental i FRIEDA BELLE GOODMAN SAMUEL SOLOMONSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If Nem 27 Is m any Injury or other traum page. 10319 INSLEY ST. Silver Spring, MD 20902 SAMUEL SOLOMONSON **FATHER** 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FALLS CHURCH, VA KING DAVID MEMORIAL GDNS 1-3-00 22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Funeral Service License ald W. Kever 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical ANTERIOSCURIOTE CANDIO MECULAR OLSEASE **Examiner** Due to (or as a consequenca of): Examiner ettending physician and for use es the bunel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): certificate be exec Physician/Medical Due to (or as a consequence of): 23h. Did tohacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. signed by t 1 Yes 2 No 3 Probably Wunknown Division of Vital Records. à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? has 1 ☐ Yes 20 No 28 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Chack only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 DER/Outpatient 3 □ DOA funerel 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Data of injury (Month, Dey Year) 28c. Injury at Work? After t Certification: Natural 2 Accident 5 Panding investigation after deeth. 1 Yes 2 No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homlcida 24 hours a Funeral D 29a, Cartifia 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the causa(s) and mannar as stated. Medical within 24 hor To the Fune completely fi Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. one the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signa and title of certifier 0 CALL MAGGIN (OME DECOMBOS 31, 1998 015236 2

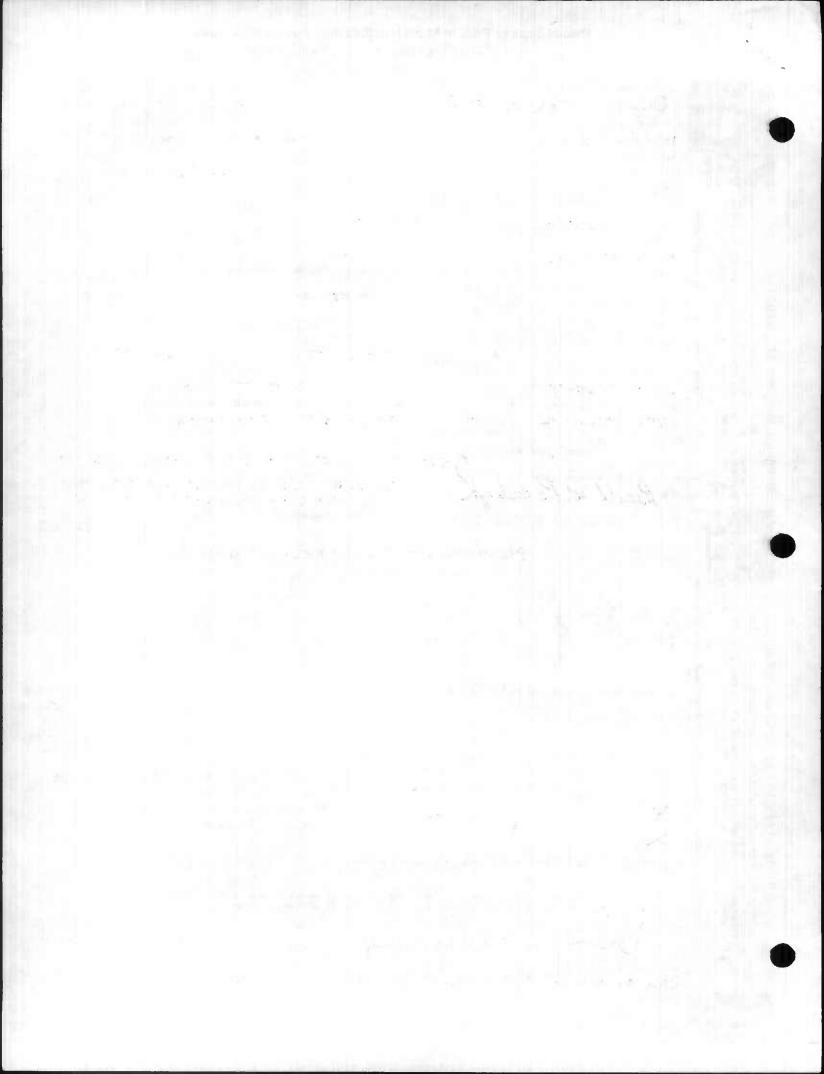
State Registrar 31. Date filed (Month, Dey, Year) **JAN 0 6** 2000

32. Registrar's Signature

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

CKU WHLOUS, WD. INVS CockVIUT PIKE, PockVIUE MO VOBSY

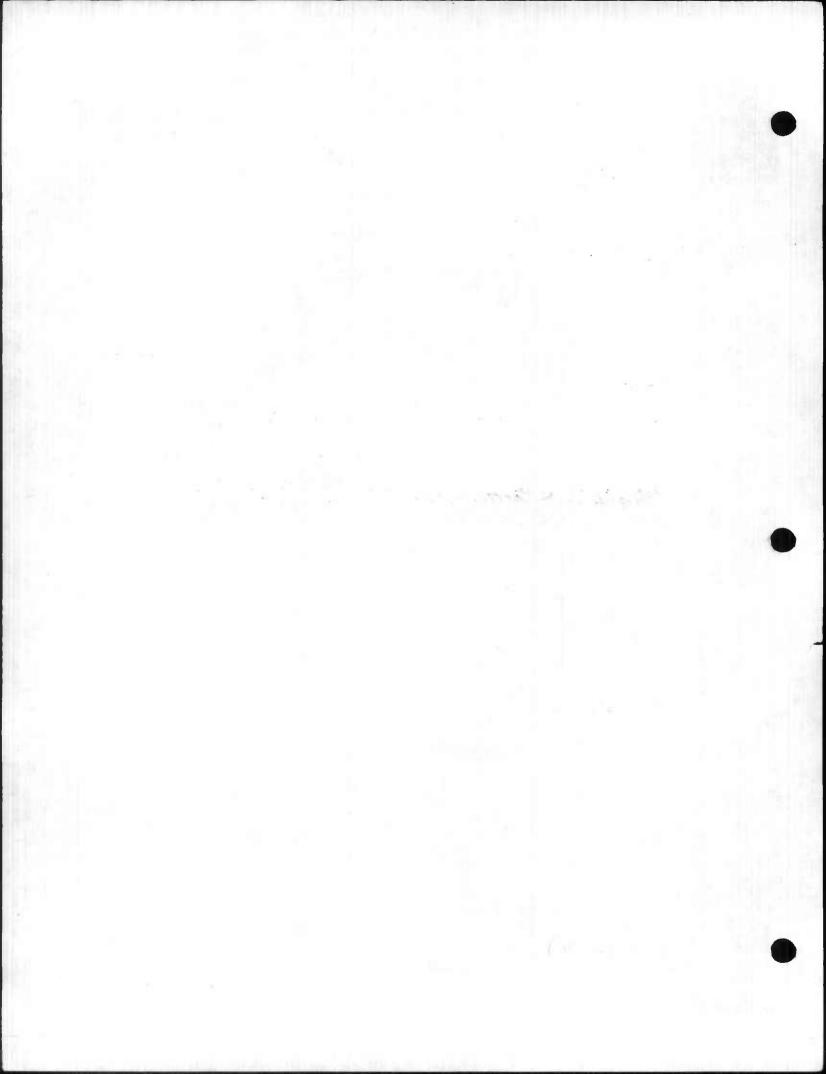
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State of Maryland / Department of Health and Mental Hygiene 99 1, 2550

						Ce	rtificate	of	Death		Reg. No.	J 60 1	47990-	
Physician	1. Dec	edent's Nam	a (First, Middle, La	ist)						2. Data of I	Dev	Yaar	3. Time of Death	
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Funeral Director	2	al Security N 53.56.	8221	Sax 7 1□M 2区F	90 / Age (In yrs. I	last birthday) Yrs.	Months (	Yaar Days	If Undar 24 Hrs Hours Min		Dey, Year)	9. Birti	hplace (State or Foreign untry) RUSSIA	
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be notified Director	10e. St	reet and Nur	MONTG	OMERI	211	VER SE	10f. Zip C	oda			10g. Citizen	of What Co	untry?	
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iner must Funeral	11. Ma	rital Status	.0.1001001	12. Was Deced	lent Ever in U.	S. 13.			lispanic Origin? ( an, Mexican, Pua	Specify Yas or I	No- 14. F		rican Indian,	
þ	3	V	ed 2 Married 4 Divorced	Armed Ford 1 Tas 2 If Yas, Giva Yaar or Dat	2 □XNo		n Yas, specify 1 □ Yas 2 <b>X</b>		an, Mexican, Pua Specify:	no Hican, atc.)	Spe	llack, White	a, atc. WHITE	
pete		/Snec	15. Decedent's E	ducation		16a. Dece	dent's Usual (	Occup	ation	odkina	16b. Kind of Business/Industry			
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	Cause.	(Disease or tiated events	Injury	c	Dura to do					<u> </u>				
edical	rasultir	ig in death) l	ast		Dua to (or	as a consec	juence of):							
3				d										
Ca	Dort II	Other stands	lanak ana ditiana a	antido de esta el co	th hud not once	Minm in the s	adad daa aa		on in Dord I	nah Di	d tabasas usa	o o m tellby it o	to the sause of death?	
Physician/	Part II.	_	PERIPHER				noonyng cau	ad gn	with Fail.				to the cause of death?	
			\_ \_ \								Yes XN	اع العال	July 4 Oliknowi	
eleted by Physician/										24a. W	s an autopsy	24b.	Wara autopsy findings	
Completed										pe	rformed?	1	available prior to completion of cause of death?	
E C										45	Yas 2 N		1 ☐ Yes 2 ☐ No	
Ö		e casa refer	red to medical						00 Di ( D				TE Tes ZE NO	
0	аха	s casa referi minar? Yas 2□		Hospital:	noticet all	ED/0:+ *	4 2 CC	Ott		eath (Check on)		When 10	a.66.1	
: To		ner of Death		1 U In		28b. Tima o			4 🗆 Nursing	Homa 5 A Ra	sidence 6 Li e how injury oc		ciry)	
Certification:	1 0	(Natural	5 Pending invastigatio	28a. Date of (Month)	, Day Year)	Injury	м	Wo	rk? Yes 2∐No		,,,,,			
Ca	30	Accidant Suicide	6 ☐ Could not b	e con place o	of Injury - At ho	me farm et				28f. Location	(Street and No	mber or Ri	ural Route Number,	
E.	40	) Homicida	datarmined	building	, atc. (Specify	1)				City or 7	own, Steta)			
edical C		artifier theck only	1 Certifying Ph 2 Medical Exam	nysician: To the b niner: On the bas and manns	is of axaminat	wledge, deat ion and/or in	n occurred at vastigation, in	tha tii	ma, data and place	ce, and dua to the	a cause(s) and a, data end pla	menner as e, and due	stated. to the cause(s)	
completely filled in by the funeral director, page  Medical Certification: To Be Com	-		title of certifiar	and mante			29c. L	Licens	e number		29d. Data sig	ned (Mont	h, Dey, Year)	
		. (-	15 W	1				320			01.04			
	00.11		, ,				Divi							
	1		ass of person who CHAEL BA					F 7	VE CITY	יחתם משנ	NG MAI	ייא א. דעכ	D 20904	
21			th, Day, Year)		TTTOT I		MESTIK.	ı F	ME' OIT,	VER SPR	ING, MAI	/TTWIN	20904	
State	31. Dat			6	gistrars Signal	4	Loon	A.	/					
gistrar		J	AN 05 20	UU /		10.	payson	100						

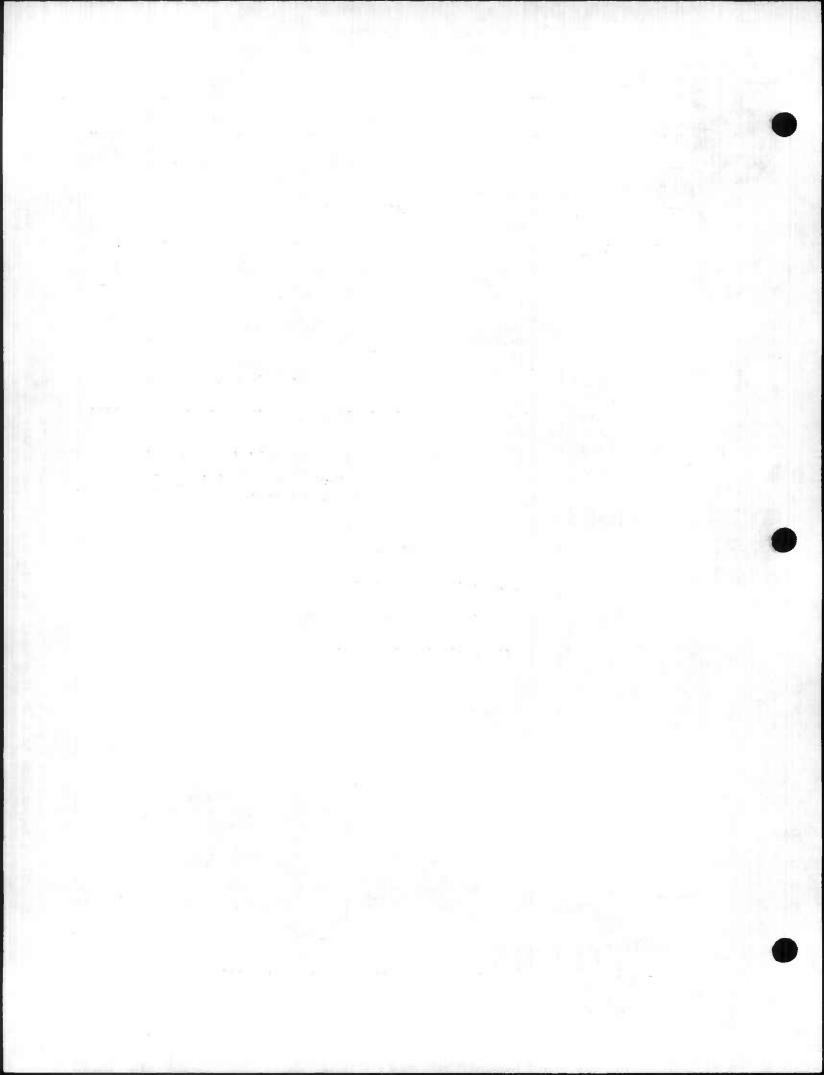
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 42559

			Ce	rtificate of	Death	1	Reg.	No.	<i>a</i> ′	7 12 0 0 27	
	1. Decedent's Name (First, Middle, L	ast)					Date of Death	_	Veer	3. Time of Death	
Physician /Medical	MARY S	MITH				DE	CEMBER	29, 1	9'99	1:27pm	
Examiner	4a Facility Name (II not Institution, gi					wn, or Locatio		4c. County			
	HOLY CROSS HOSPI					R SPRI			GOMER		
Funeral Director	5. Social Security Number 6. 578 – 34 – 3410  Usual Rasidance of Decedent	Sex 1□M 2 F 7. Age (In y 1 B 6	rs. last birthdey) Yrs.	If Under 1 Yea Months Dey		Min. M	Dete of Birth Month, Pay, Yea ay	1913	9. Birthpl Coun	lace (Stete or Foreign fry) MD	
In the Maryland or 28e-f show a notified at Mrector	10a. State 10b. County MD Montgom		City, Town or Lo	ocation lver Spr	ing				11	0d. Inside City Limits 1 Yes 2 No	
3a or 28 at be not	10e. Street and Number 2217 Richland St	reet		10f. Zip Code	20910	)		Citizen of V			
n 72 hours after death with the Marylan "natural", or thems 23s or 28s-1 show sideal Examiner must be notified at leted by Funeral Director	11. Marifal Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	ben, Mexicar	n, Puerto Rica	pecify Yes or No- o Rican, etc.) 14. Rac Ble Specif			an Indian, etc. I a C k	
filed within 72 ho Hygiene. ther than 'naturn int, the Medical.	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) Housewife					16b. Kind of Businass/Industry Private			
B sept	17. Father's Name (First, Middle, Las James Crockett	ry Bran	st, Middla, Maid don	len Sumam	e)						
and 2 should saith and Mer n 27 is marks wr traumatic	19a. Informent's Name/Reletionship Jean Seagears - Da			ng Addrass <i>(Strae</i> Richlan							
1 2 1 2 P	20a. Method of Disposition  X Burial 2 Cramation 3 ( 4 Donation 5 Other (Spec	Removel from State	cemetery, crea	ek Cemet				Location -			
permit. Pag Department Important: i any injury o otice.	21. Signafure of Funeral Service Lice	nsee	22	RName Nand Add 600 Kenn	est of Facility	o, Mor	ticians	, Inc	DC 2	20011	
	23a. Pert1. Enter the disease, or cor shock, or heart failure. List only	nplications that ceused the de				-		,		Approximate Intervel Between	
Colors be assected ficate be assected for physician and the burist-transit st the burist-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Congestiv	(or as a consec	Failure				4		Onset and Death	
ertificate be assocuted ling physician and is as the burist-transit Medical Examit	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury thet initiated events	Chronic C		ive Lung	e Lung Disease						
nding phy usa as the	rasulting in death) Last	Bilateral			ns						
r requires that the death certificate be assected been signed by the attending physician and should be detached for use as the burist-transiteted by Physician/Medical Examir	Part II. Other algnificant conditions	contributing to death but not resulting in the underlying ceuse givan in Part I.					23b. Did tobacco usa contribute to the caus  1 Yes 2 No 3 Probably 4				
							24a. Wes en au performed	itopsy	ava	ora autopsy findings allable prior to impletion of cause death?	
The lay ate has page 2							1 🗆 Yes	X 2 🗆 No	10	Yes 2 No	
ystclen: The lav s certificate has director, page 2 To Be Comp	25. Was case referred to medical axaminer?				26. Place	a of Death (Ch	eck only one)				
nysic his ca Il dire	1 ☐ Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpatier	nt 3D DOA	ther: 4 Nu	ursing Homa	5 Rasidence	6 □Othe	ar (Specify	1)	
us or Attending Prince and Director: After the led in by the funeral Certification:	27. Manner of Death 1 Natural 5 Pending investigation		28b. Tima o Injury	W	ury at ork? ] Yas 2 []		Describe how in	njury occurr	ed		
s after de la Direct de la Direct de la Direct de la Direct Certific	3 ☐ Suicide 6 ☐ Could not 6 determined	28e. Place of Injury - Ai building, atc. (Spe	t homa, farm, str city)					<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>			
he Hospi in 24 hou he Funer pletely fil edical	29a. Certifier (Check only one) 1	hysician: To the best of my k miner: On tha basis of exami end manner stated.	nowledga, death	n occurred at the vastigation, in my	time, date an opinion, daa	nd place, and o oth occurred at	the time, data	e(s) and ma and place, a	nner as st and dua to	ated. the cause(s)	
with with Some	//	Jemuy completed ceuse of deeth (II		D:	35791			Date signed Decemb	per 3	0, 1999	
	30. Name and address of person who Merlyn Vemury 9	801 Georgia A				MD 20	906				
State Registrar	31. Date filed (Month, Dey, Year)  JAN 0 5 20	32. Registrar's Sig	gnature $\mathcal{G}$ .	Spark	2						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42560 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DECEMBER 31, INGA GRUNEWALD SHARP 1999 2:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ILVER SPRING
If Under 24 Hrs. 8. Date HOLY CROSS HOSPITAL MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2CKF Yrs. 102-03-5539 Director 4, 1902 97 AUG. GERMANY Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits \*netural", or items 23s or 28s-f shoredcal Examiner must be notified at 1 Yas 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country's 8505 SPRINGVALE ROAD 20910 UNITED STATES death Funeral Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mertel Hyglene. Important: If Nem 27 Is marked other than "natural", or its any finlury or other traumatic event, the Medical Enemi 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify by 3 D\Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 MILLINER HAT MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be UNKNOWN UNKNOWN 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA A MARTIN - GRANDDAUGHTER 16616 HARBOUR TOWN DRIVE, SILVER SPRING, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 31CR 1 ☑ Burial 2 ☐ Cremation 4 Donetion 5 Other (Sq city) CYPRESS HILLS CEMETERY 1/10/00 BROOKLYN, NY Funeral Se HINES-RINAEDIFACTUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 15 MIN. RESPIRATORY FAILURE Examiner Due to (or es e consequence of): Examiner 15 MIN ASPIRATION The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760. 2 MONTHS MALNUTRITION Physician/Medical the Due to (or as a consequence of) 88 DEHYDRATION ate hes been signed by the a page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Be Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No tXXinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending 1 Yes 2 No 24 hours after deeth. 2 Accident investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

2

31. Date filed (Month, Day, Year) State JAN 05 2000 Registrar

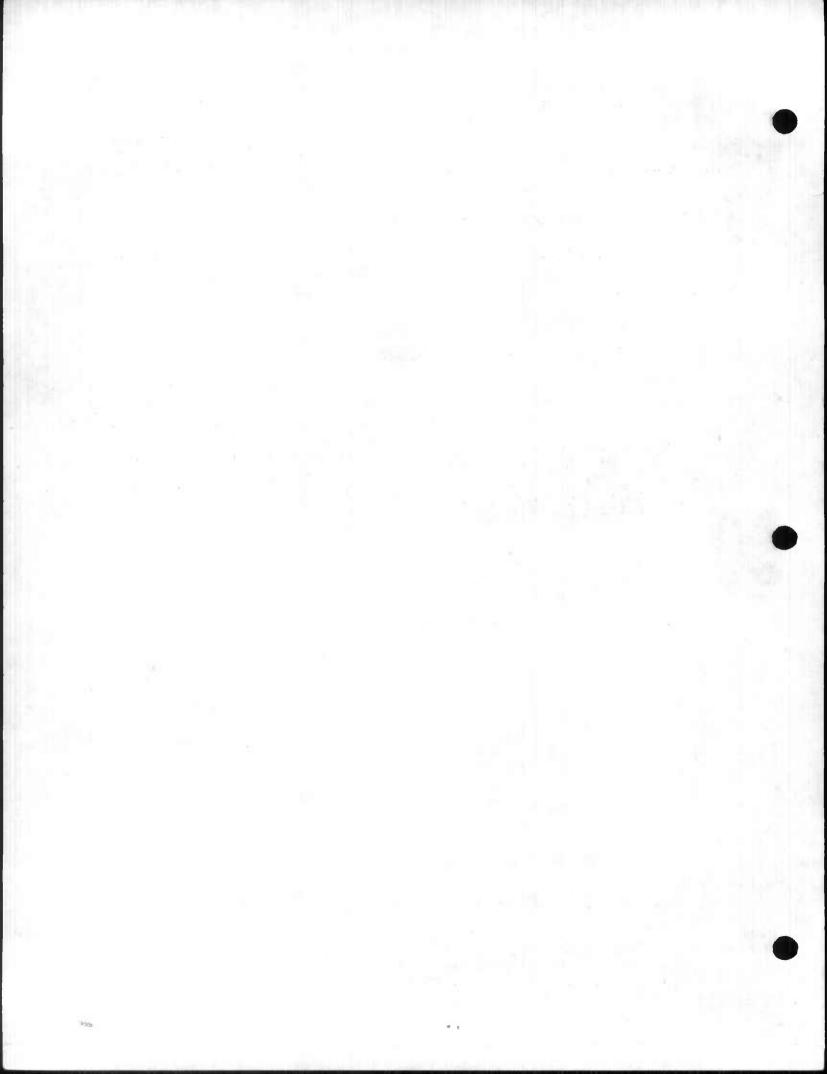
Thomekhno

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEWAL K. SHARMA, MD 10620 GEORGIA AVENUE SILVER SPRING, MD 20902 32. Fingistrar's Signature

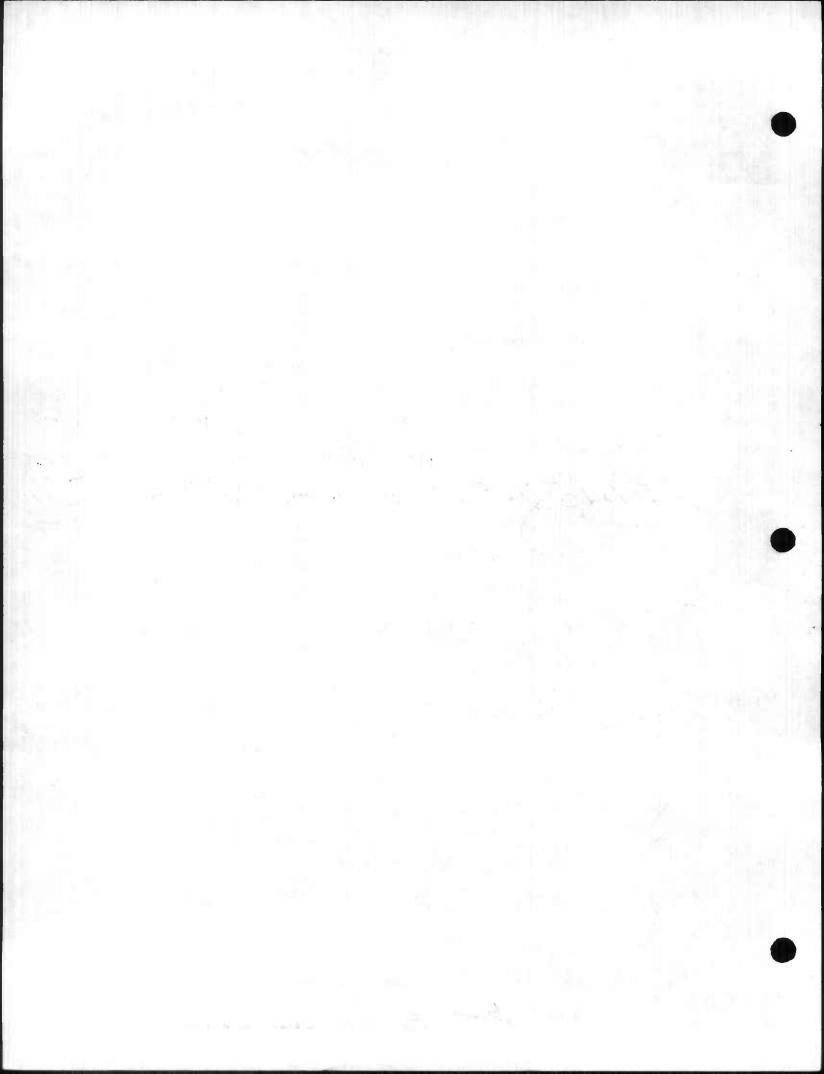
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DECEMBER 31, 1999



State of Maryland / Department of Health and Mental Hygiene 99 42561

			Ce	rtificate of	Death		Reg. No.	- 16001								
Dhysisian	1. Decedent's Name (First, Middle, La	st)				2. Date of 8 Month	Death	Year tr. (								
Physician /Medical	NEANG S	SEM				DECEMBE		1991 1941								
Examiner	4a Facility Name (If not institution, give WA) HOGON ADUSTIS				4b. City, Ton TAKOWA	m, or Location of Des		of Death SOMKINY								
Funeral Director	5. Sociel Security Number 6. S 216-41-3300	86	s. last birthday) 9 Yrs.	Months Days	If Under 2 Hours	Min. (Month, I	Birth (Day, Year) 3,1930	9. Birthplace (State or Foreign Country) CAMBODIA								
2 .	Usual Residence of Decedent  10a, Stete 10b, County	100 (	City, Town or Lo	anting				104 1-14-05-11-1-								
ter death with the Menylan ter death with the Menylan terms 23e or 28s-f show the motified at the motified at Director				R SPRING				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo								
or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?								
23a 23a		RACE #103		20	903		CAMB	ODIA								
D 8 8 7		12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Wes Decedent of If Yes, specify Cub 1☐ Yes 2∑ No	an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)		ce - American Indian, ack, White, etc.								
72 hours natural;			16a. Dece	dent's Usual Occu	pation	16b. Kind of Business/Industry										
1 21215-0 ed within 72 ho ygiene. or than "naturi ft, the trades!	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most d)	of working	Too. Tank of Duminosa including									
N PEL N	12	0011090 (1 401 01)	FA	ACTORY WO	RKER		MANUF	ACTURING								
O EISE A					18. Mother	's Name (First, Midd	le, Maiden Suman	ne)								
should be not Mental marked o umatic eve	NEANG SUM				SO	ME MEK										
and and and and and and and and and and	19e. Informant's Neme/Relationship (		19b. Maili	ng Address (Stree	and Number	or Rural Route Num	ber, City or Town,	State, Zip Code) 20903								
	YAN DOEUK/SPOUS		1000	QUEBEC	TERRAC	E #103 S	ILVER SP	RING, MĂŔŸĹAND								
Malitimore, semit. Pages 1 a Mpartment of Hea mportant: If Item my Injury or other most.	20a. Method of Disposition  1  Burial 2 XX remetion 3  4  Donetion 5  Other (Specification)	Removel from State	cemetery, crea	sition (Name of matory or other pla KE CREMA		1/1/200		City or Town, State VILLE, MARYLAND								
and and and and and and and and and and	21. Signature of Funeral Service Liber	1		2. Name and Addr			-									
Dep Dep Per Per Per Per Per Per Per Per Per Per	VF Dans	Tu	11	800 NEW	HAMPSH			NERAL HOME, INC. SPRING, MD 20904								
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the decone cause on each line.	ath. Do not ent	er the mode of dy	ng, such es c	ardiac or respiratory	arrest,	Approximete Interval Between								
Physician								Onset and Death								
/Medical Examiner	Immediate Cause (Fine) disease or condition	RESPIRATOR	Y FML	WRY												
	resulting in deeth)		(or as a consec													
sir ed		METABOLIC	pc1009	>												
Gox boy of the conflicate be executed e ettending physician and of for use as the bufal-transit sician/Medical Examiner	Sequentially list conditions, if any leading to immediate		(or as a consec													
DE/DU, ifficate be ext g physician as the burlai-	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c. CHADONIC A	100 for	Dn.												
. BOX 06/00 Jeeth certificate be tethording physicis dior use as the bu ician/Medical	that initieted events resulting in death) Last	Due to (	(or as a conseq	uence of):												
A ling		d						t .								
beth c for us																
the de sched	Pert II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause gi	ven in Pert i.	23b. Di	d tobacco use co	intribute to the cause of death?								
T de de d	ISCHOLIC MYSOMO!	al disable				1(	Yes 2 No	3 Probably 4 Unknown								
require require seen si should							24a. Was an autopsy performed? 24b. Were autopsy available prior completion of									
The law ate has the page 2 s							Yes 2 No	of death?								
certificate rector, pag	25. Was case referred to medical				OC Plans		/	1 Yes 2 No								
	examiner?	Hospital:		- 20 DOA 01	her	of Deeth (Check only		(C								
D & Se	27. Manner of Death  1 Naturel 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju	4LI NUE		e how injury occur									
l or Attending after deeth.  Director: After din by the fune fune ertification	2 Accident Investigation 3 Suicide 6 Could not be	9	home form str		- 201		(Street and Numi	ber or Rural Route Number,								
or Attended Director:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, ractory, ornice			own, Stete)	oor or rigial rioute rioinosi,								
To the Hospital or Attending within 24 hours after deeply from the Funeral Director: After completely filled in by the fune Medical Certification		ysician: To the best of my kn niner: On the basis of examin														
within 2- worthe F complete	300	and manner stated.														
or with	29b. Significate and title of certifier	- Cont	()	29c. Licen				od (Month, Day, Year)								
3	1	mo. Com	/	015	136		Occombor	08, 1999								
	30. Neme end eddress of person who call MARCAN IN				wills,	, MO 108	552									
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Sign		1												



State of Maryland / Department of Health and Mental Hygiene
Cartificate of Dooth

	1 Decedent	Name (First, Middle, La	net)		Cei	lincale	01	Death	2. Date of Da	Reg. No.		3. Time of Death
/sician	CONO	SCOLARO	ist/						Month DECEME	Day	1 9999	5:07AM
ledical aminer	4a Facility Na	ISLE OF SK		oer)				4b. City, Town, o	Location of Daat		of Death	3,07111
ral tor	5. Social Secu 217-42		Sax 7. MM 2□ F	Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days			th ay, Year) 1930	9. Birthplac County ITALY	ca (Stete or Foreign
rector		nca of Decedent		100 City	y, Town or Lo	nation					100	t tasida City t imita
-	10a. Stata	10b. County				Catton					100	Inside City Limits
ect	MD 10e. Street ar	HOWARD and Number		HIG	HLAND	10f. Zlp	Coda			10g. Citizen of	What Country	Λ
Ö		ISLE OF SKY	E DRIVE				207	77		USA		
by Funeral Director		atus r Married 2 Married wed 4 Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	es? No	1	Was Deced If Yas, spec			Specify Yes or Norto Rican, atc.)	Specify Yes or No- to Rican, atc.)  14. Race - Amarican In Bleck, Whita, etc. Specify: WHIT		
leted leted		15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occupation (Give kind of work done duping most of working					16b. Kind of B	usinass/Indu	stry	
mpie	-	/Secondery (0-12)		College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired)  BARBER			ргтат	IL/HAIR	
TS. Decer (Specify only high property)  Elementery/Secondery (0-12)  12  17. Father's Name (First, Midd JOSEPH SCOLAR)  19e. Informent's Neme/Reletic SEBASTIANA SCO  20a. Method of Disposition  1 \[ \times \text{Burial 2} \] Crematic  4 \[ \times \text{Donation 5} \] Other	lame (First, Middle, Las	)		DA	KDEK		18. Mother's N	ame (First, Middle				
		,					SPATICO					
	nt's Neme/Reletionship	Type, Print)		19b. Maili	ng Address	(Stree	t end Number or I	Rural Route Numb	per, City or Town	Stete, Zip C	Code)	
	IANA SCOLAR	o (SPOUS	E)	6647	ISLE	OF	SKYE DRI	VE HIGHI	AND, MD	20777		
	20a. Method o	of Disposition	Removal from St	20b. P	riace of Dispo emetery, cred E OF H	metory or or	ther ple	ece) METERY	Date 1-4-2000	20c. Location SILVER		
(	21. Signettife	of Fundaral Service Lice	Mull	6	7 2				ES-RINAU			HAMPSHIRI
	Immadiate Codisease or coresulting in di	ondition	one cadse on eac	Due to (o					ac or raspiratory a	arrest,	11	Approximate nterval Between Onset and Death
5	resulting in or	outi,				quence of):					i L	
Examiner			b. Ris	PIRKT		AR	Ri	ST			i_	
Exa	Sequentially if any, leeding cause. Enter	list conditions, g to immediate Underlying use or injury		Due to (or	r es a conse	quence of):					1	
dical	Cause (Disea that initieted resulting in de	BAGII62	G	Dua to (or	r as a consec	quence of):						
		L	d								1	
Physiclan/M			0.									
ysic	Part II. Other	significant conditions	contributing to deat	th but not resu	ulting In tha u	nderlying c	ause gi	iven in Part I.		\ /		he cause of death
by Ph									- 1	Yes 2000	3 Probe	ibly 4 Unknow
Completed by									24a. War perf	s an eutopsy ormed?	avail	e autopsy findings lable prior to plation of cause eeth?
Con									10	Yes ZONO	10	Yes 2□ No
Be	25. Was case examiner	referred to medical	Manakat				10.		eath (Check only	one)		
C	1 ☐ Yes	21200	Hospital: 1 Inp		ER/Outpatie		JA		Home Res			
Certification:	27. Manner of	el 5 Pending dent investigation			28b. Time o Injury	М		Yes 2□No		how injury occu		
Certifi	3 ☐ Suici 4 ☐ Hom		28e. Place of building	f Injury - At ho , etc. (Specify	ome, farm, st y)	reet, factory	y, office		28f. Location City or To	(Street end Num. own, Stete)	ber or Rural	Houle Number,
dicai	29a. Certifier (Check or one)		nysician: To the be miner: On the bas and manne	is of examinal								
29a. Certifier (Check of one)		a and title of certifier	Λο			290	. Licen	sa number	29d. Date signed (Month, Dey, Yea			ley, Year)
8	V		/ V1						4			

29c. Licensa number

Jackelle (M)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) I SA bellA MAR FIRE, M.D.

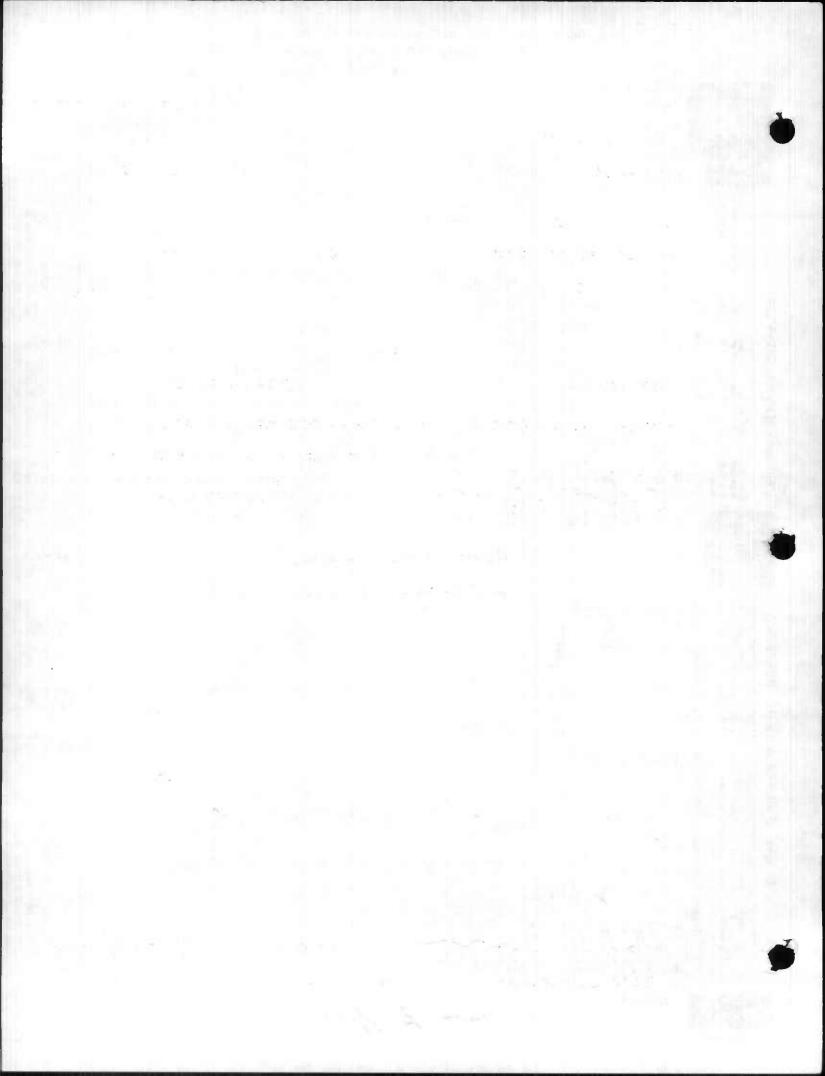
34.18 OLMANOOD COURT # 111 OLMY M

31. Date filad (Month, Day, Yeer)

State Registrar

JAN 0 3 2000

32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 42563 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Enzo Santucci 31, 1999 8:10 pm December 4a Facility Nama (II not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death ilver Spring Mon H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Holy Cross Hospital Montgomery 9. Birthplace (Stata or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 59 Yrs. 579-54-4756 Sep 25, 1940 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring 1 Yas 2 No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 2703 Woodedge Road 20906 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 [X]No If Yes, Giva Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Barber Hair 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Ferruccio Santucci Rachele Collepardo 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Olga Santucci/ Wife 2703 Woodedge Road, Silver Spring, MD 20906 ce of Disposition (Name of Data 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Plece of Disposition (Nama of cematary, cremetory or other place) 1X Burial 2 Cremation 3 Removal from Stata Gate of Heaven Cemetery 1/5/2000 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Fameral Service License ober a 500 University Blvd., W, Silver Spring, MD20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Hypotension 3 days Due to (or as a consequence of): Respiratory Failure 3 days Dua to (or as a consequence of): Renal Failure Dua to (or as a consequence of): d. Stroke 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-transit

6

page 2 s has

edical Certification: To

certificata

this funeral

After Attending Division

death.

To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

12

the death cartificate be executed

The law requires that Records.

Box 68760.

P.O. |

of Vital

permit. Pages 1 and 2 should be filled via Department of Health and Mental thygis Important if Nem 27 is marked other to eny Injury or other traumatic avent, ID DAGS.

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

é

Completed

**Funeral** 

Director

the Manylend

Baitimore, Maryland 21215-0020

se filed within 72 hours efter death with the Marylen Hyglene. I Hyglene of the Trans 23s or 28s-f show went, the Medical Essant se must be notified at

Examine Physician/Medical by Completed Be

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Part It. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 25. Was casa referred to medical Hospital: 1 XInpatient 2 ER/Outpatient 3

28e. Place of Injury - At homa, farm, street, fact building, atc. (Specify)

28a. Data of Injury (Month, Day Year)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🖾 No 1 Yes 2 No

26. Place of	Death (Check only one)
DOA Other: 4 Nursin	g Home 5 ☐ Residence 6 ☐ Other (Specify)
28c. tnjury at Work? 1 Yes 2 No	28d. Describe how injury occurred
ory, office	28f. Location (Street and Number or Rural Routa Number, City or Town, State)

200	(Check only one)	2	Medical 1
29h	Signature an	d titla	of certifier

1 ☐ Yes 2 ☐ KNo

27. Manner of Death 1 Netural

2 Accident

3 Suicide

4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

-	0 4
	(//
	Eliometerno.
	EUC IMECANINI

5 Pending invastigation

6 ☐ Could not be

D40804

January 1, 2000

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

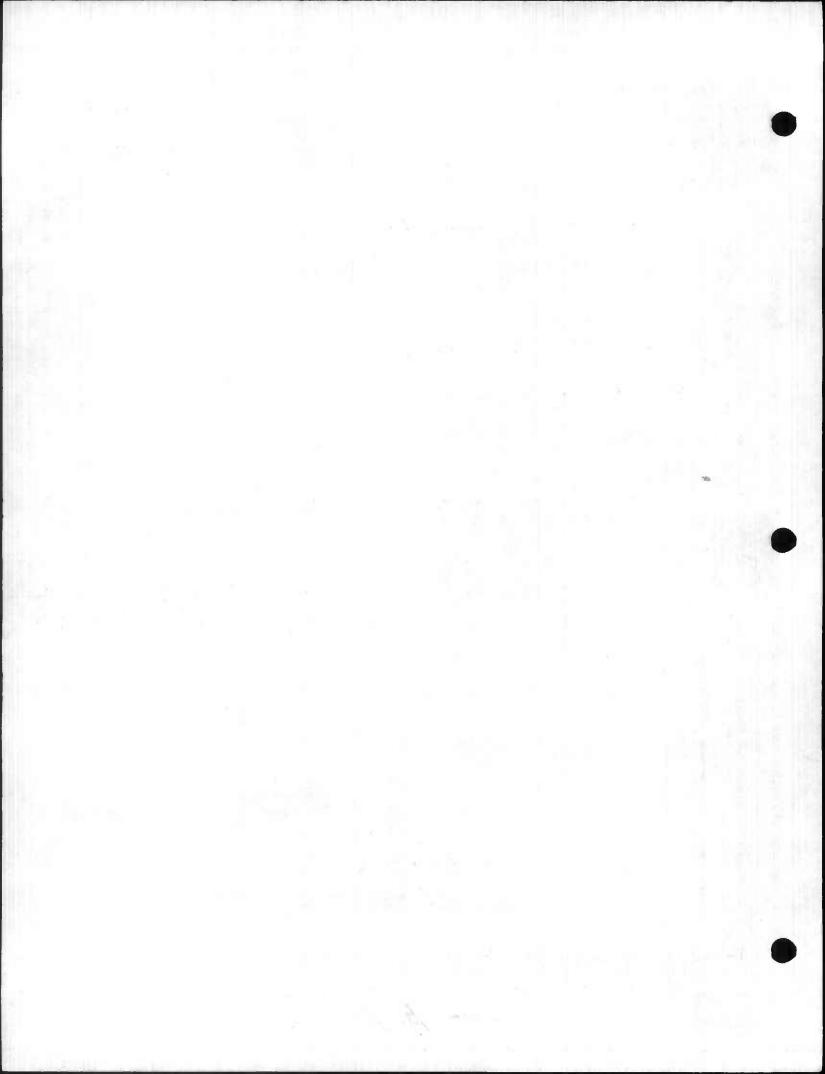
Kewal K. Sharma, M.D. 10620 Georgia Ave., #114, SilverSpring, MD 20902 31. Dete filed (Month, Day, Year)

State Registrar

JAN 0 4 2000

32. Registrar's Signatura

28b. Tima of Injury



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 12561 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** SAIDMAN 12 30 1999 3:40 AM RENA /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE MONTGOMERY CASEY HOUSE If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M XXF Months Hours Director 577-10-0972 87 5/3/1912 OHIO Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits must be notified at the Maryla 1 Yes 2 □ No Director SILVER SPRING MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rema 23a or 15101 GLADE DRIVE APT. #3A 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or han the Medical Examiner Black, White, etc. filed within 72 hours after Hygiene. Wer then "natural", or its 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) RETAIL 12 BOOKKEEPER 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant; if Item 27 is marked oth fury or other traumatic even Be SARAH FUNGER JULIUS SAND 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 KEYSTONE COURT, GAITHERSBURG, MARYLAND 20878 SANFORD E. SAIDMAN 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 12/31/99 Department of Important: If it any injury or once. 1 Buriel 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GARDENS FALLS CHURCH, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Cause (Finel disaese or condition resulting in death) /Medical METASTATIC OVARIAN CARCINOMA 13 MONTHS Examiner Due to (or as e consequence of): Examine The law requires that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) 67 65 USB P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. and the 5 1 Yea 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? peed has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of After Certification: or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 [] Homicide 29e. Certifier 1/X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DECEMBER 30, 1999 D0037620 30. Neme and address of person who completed cause of death (Item 23k) (Type, Print)

**DHMH 16 Rav 6/95** 

State

Registrar

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6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855

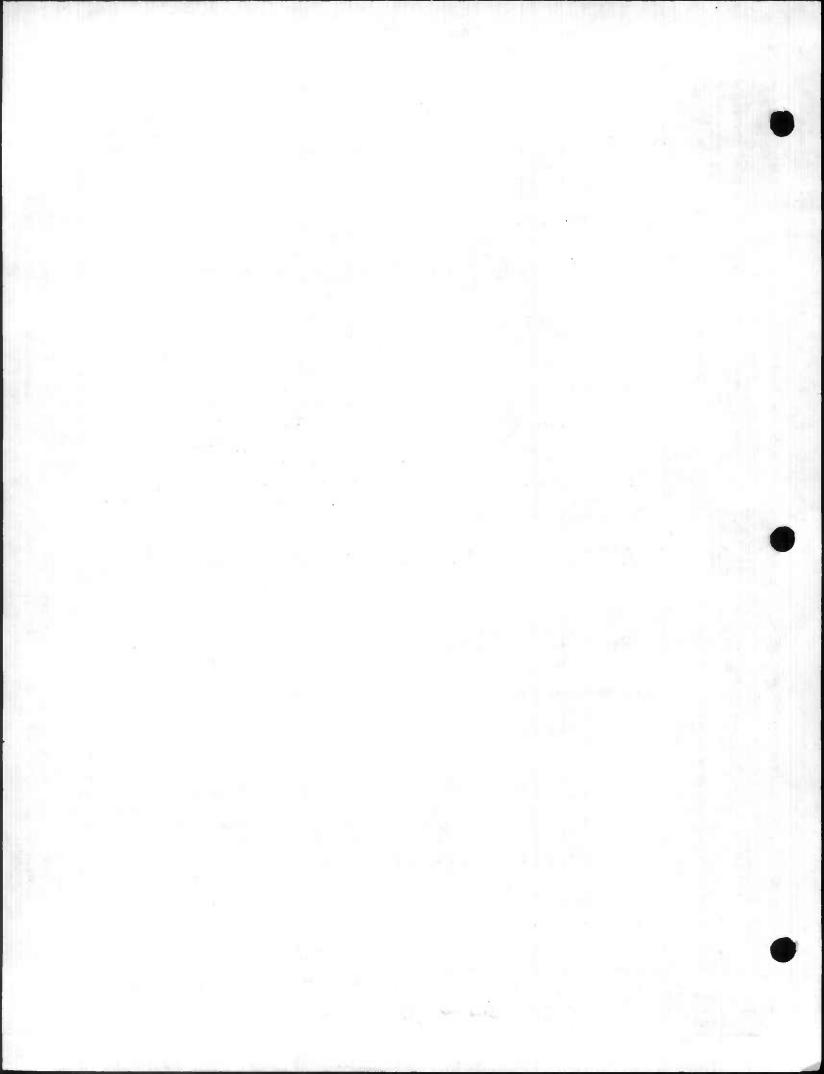
CASEY HOUSE,

32. Registrar's Signature

MARK S. GODEC, M.D.,

2000

31. Date filed (Month, Day, Year)
JAN 0 4



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month Day **Physician** December 29, 1999 James Frank Smetana Jr. 5:31PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1X) M 2 F 64 Months Director 219-30-3388 August 20, 1935 Maryland **Usuel Residence of Decedent** 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow r 28a-f ahov notified at Maryland Oueen Anne's Stevensville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 910 Worcester Drive 21666 USA Funeral Rems ; 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. r than "natural", or iten Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑No Specify: by Specify:White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) pernit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen important: if item 27 is marked other that any injury or other treumatic event, that once. Tool and Die Maker Telecommunications 17. Father's Name (First Middle Last) 18. Mother'a Name (First, Middle, Maiden Surname) Be James F. Smetana, Sr. Margaret Regan 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn Margaret Smetana/Wife 910 Worcester Rd. Stevensville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation CenterDecember 30, 1999 Chester, MD a of Funeral Service Licens 22. Neme and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, Maryland 21619 upzer Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one sause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finet Imonth disease or condition resulting in death) Examiner Examiner the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be de by Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No funeral director, 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/2 Inpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ( Netural 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner stated. 29a. Certifier

Attending Physicien: The lew requires that the death certificate be executed Division of Vitai Records, certificate this After ne Hoepital or Attending no 24 hours after death. within 2 To the

filed within 72 hours after deeth with the Manyland

21215-0020

altimore, Maryland

P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) JAN 03 2000

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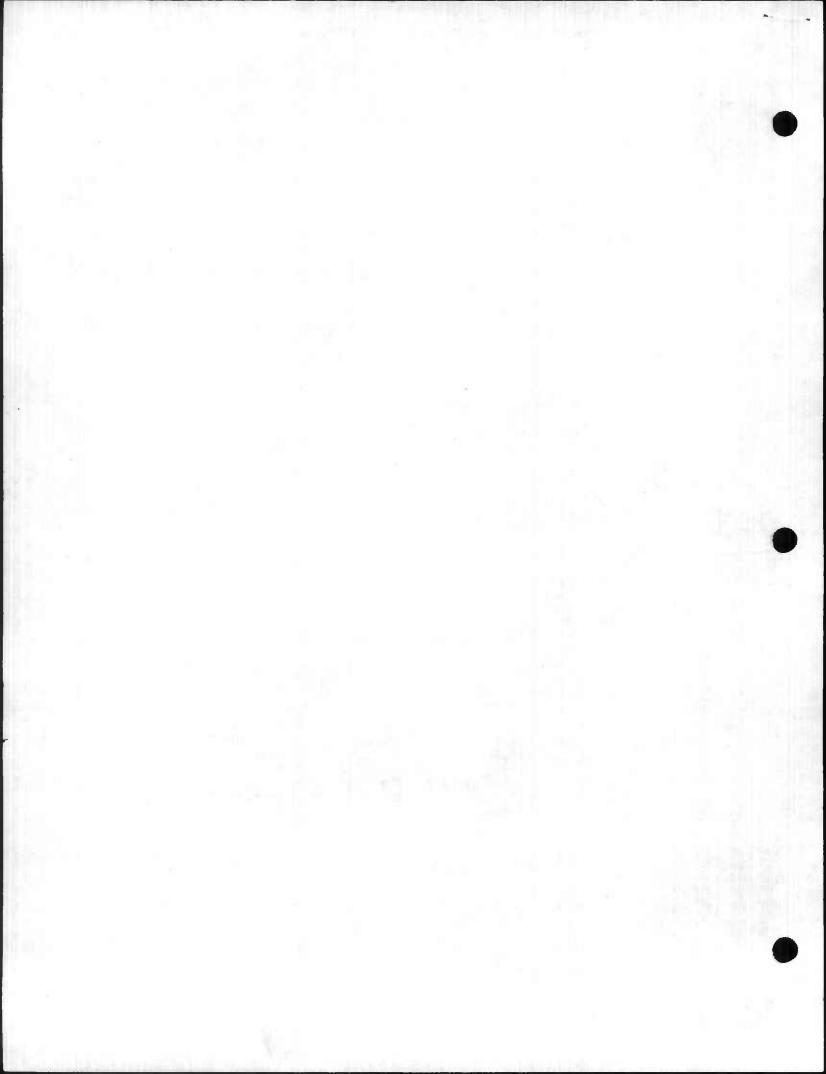
29b. Signature and title of certifier

32. Registrer's Signature

30. Name and address of parson who completed cause of death (Item 23a) Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42566 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 22 Pearline | Н. Taylor December 1999 6:00 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Dete of Birth (Month, Day, Year) Apr. 29, 19 If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** Days Hours Months 1□M 2\ F Yrs. 214-60-6729 70 1929 Director Apr. Jamaica Usual Rasidence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside Clty Limits Maryland Prince George's Hyattsville 1 X Yas 2 □ No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1001 Chillum Road #204 20782 U.S.A. death Funeral 14. Race - American Indian, Black, Whita, atc. 12. Wes Decedant Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status filed within 72 hours efter Hyglene. □Yes 2 No 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 🖺 No Specify: Black Specify: p Yas, Giva Yaar or Datas: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglene Important: if them 27 is marked other than any liqury or other traumatic svent, the pages. Homemaker Own home 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Unavailable Claradine Edwards Higgler 0 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carlton Henry / Son 1001 Chillum Road #204 Hyattsville, Md. 20782 20b. Place of Disposition (Nama of cemetery, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State Dec. 1 D Burial 2 Cremation 3 Ramoval from Stata Silver Spring, Md. 4 Donation Othar (Specify) 1999 Gate of Heaven Cemetery 22. Nama and Addrass of Facility DeVol Funeral Home 21. Signatura of Funetal Service Licenses 2222 Wisconsin Ave., NW Washington, DC 20007 23a. Part1. Enter the disaese or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Carcinoma of the Ovary with Metastasis disaasa or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner physicien and the buriel-transit the death certificete be executed Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequance of): 980 ed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Diabetes Mellitus that þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? peen 1 ☐ Yes 2 🕅 No 1 Yes 2 No

Box 68760 P.O. Division of Vital Records, The law requires page 2 s

Completed Be edical Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, is

25. Was casa rafarred to medical examinar? 1 Yes 2 No

29a. Certifier

27. Mannar of Death 5 Pending 1 X Natural invastigation 2 Accidant 3 Suicide 4 Homicida

6 Could not be determined

28a. Data of injury (Month, Day Year)

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☒ DOA 28b. Tima of

Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 28c. Injury at Work? 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier

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29c. Licanse number D20129

29d. Data signed (Month, Day, Year)

January 4, 2000

30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Hospital:

7610 Carroll Avenue #390. Takoma Park, Maryland 20912 Chacko, M.D.

31. Data filed (Month, Day, Year)

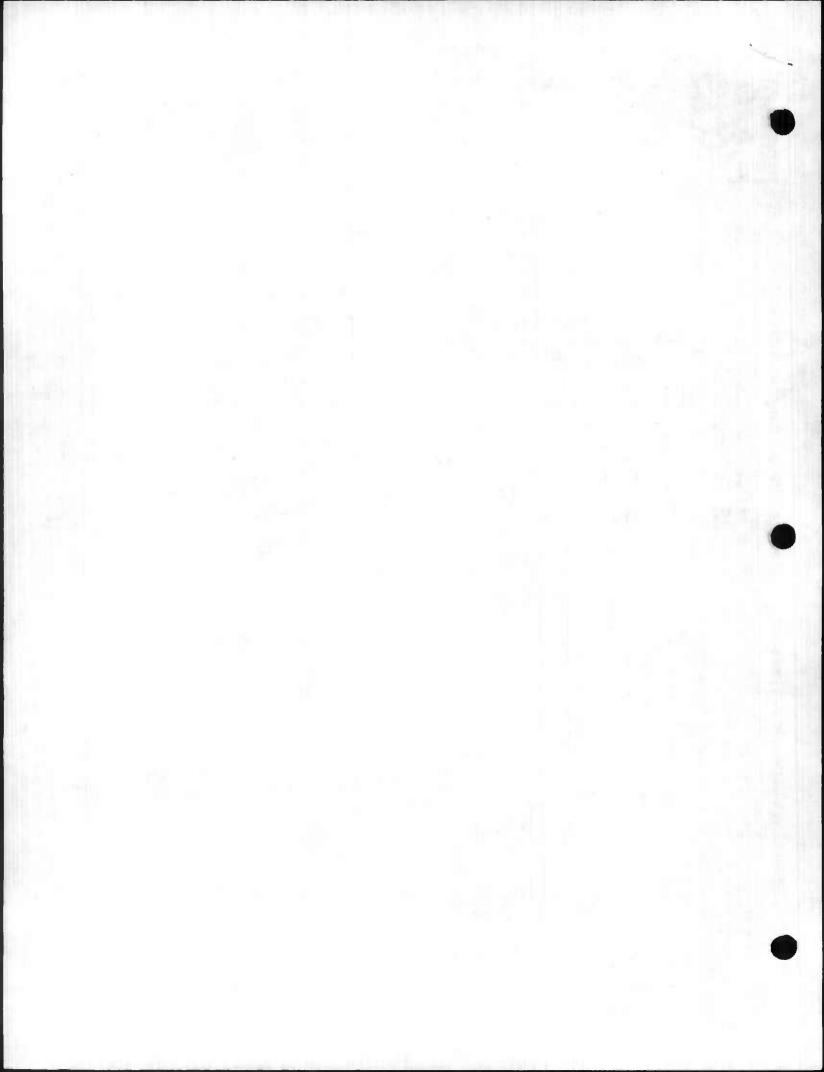
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32. Registrar's Signatura

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State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month DEC. 28, 1999 0345 ALICE Μ. VINSON 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1900 Months Days Hours Min. July 20, 1922 9. Birthplace (State or Foreign Country)
S. Carolina 218-32-6005 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 U.S.A. 17060 King James Way, #605 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2₺ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bualness/Industry Elementery/Secondery (0-12) 5th College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) James Wiggins, Sr. Frances Beale 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Gaylord Dr., Suitland, MD 20746 Jerome Vinson (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Metropolitan F/Srv. 1/2/2000 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or head feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in daeth) Due to (or as e conseque Nowan Due to (or es a consequence of): NA voltas Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did lobacco use contribute to the cause of death? 1 Yea 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1º Neturel

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show.

23a-1

'natural', or itsms 23s or

Hygiene.

2 should be fi h and Mental F is marked of

permit. Pages 1 and 2 should to Department of Health and Ment Important: If Item 27 is market

altimore, Maryland 21215-0020

Box 68760

Vital

Division

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Directo

Funeral

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Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last and physician Physician/Medical

1 Yes 2 LNO 27. Manner of Death

5 Pending

investigation 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year) DECEMBER 29,1999

KNIGNER Q.ND MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19520 Ductors Dave, Germantown, MD. 20874. 13h. D. KhiANES 31. Dete filed (Month, Day, Year)

State Registrar

Completed

Be

Medical Certification: To

certificate

this

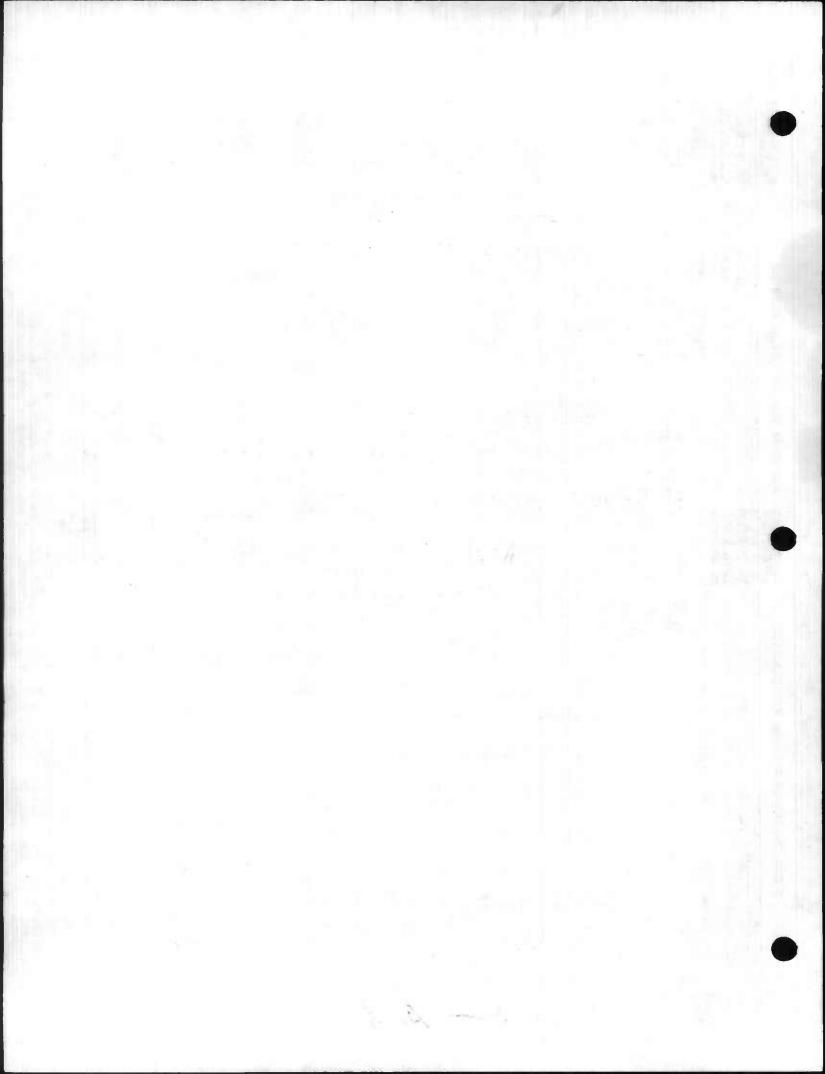
Director:

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

pepital or Attending Physician; hours after death.

JAN 03 2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ANNA L. YOWAISK December 31, 1999 3:45 pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 13201 Hathaway Drive 8. Date of Birth (Month, Day, Year) Sept 10, 1921 Maryland 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 Ø F Months 78 Director 577-28-9302 Usual Residence of Decedent the Maryland 10a. State 10b. County than "natural", or items 23s or 28s-f show the Medical Examiner must be incitied at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20906 USA 13201 Hathaway Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 's may follury or other traumatic event, the Menda. Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Chief Operator C&P Telephone Baltimore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Martha Davis William Parran Farr 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Yowaiski / Husband 13201 Hathaway Drive, Silver Spring, MD 20906 20a. Method of Disposition

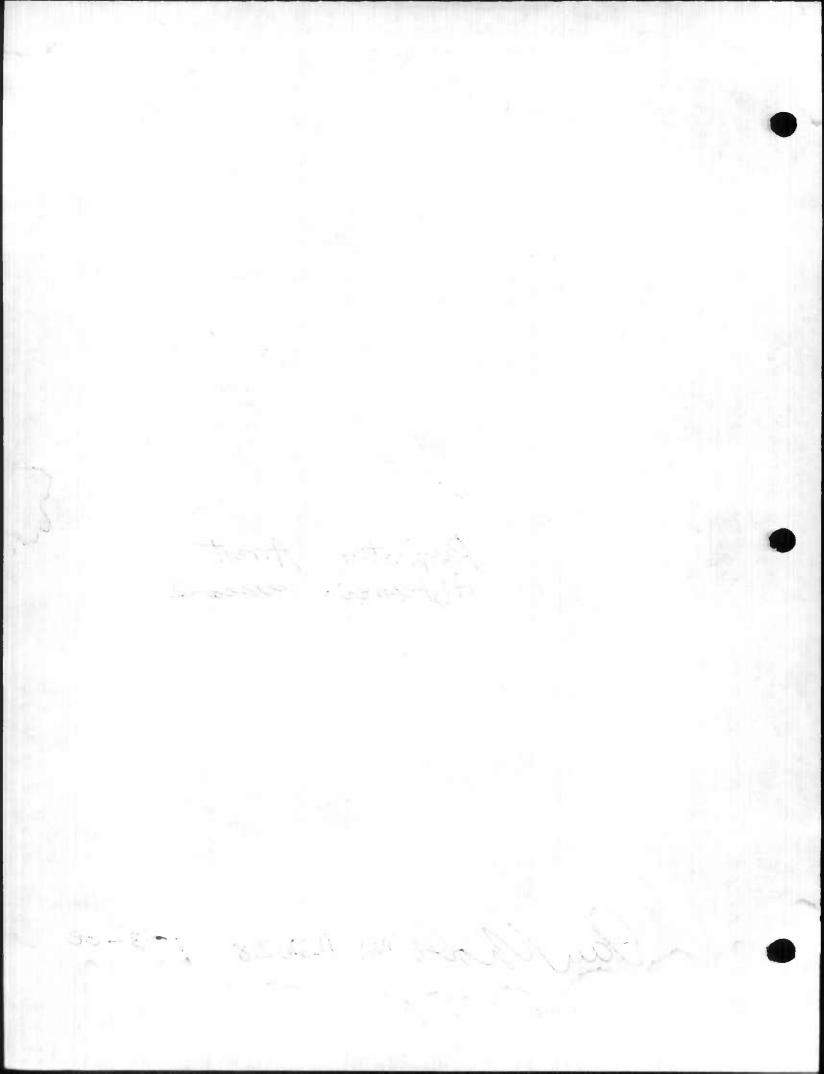
1 □ Bunat 2 □ Cremation 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1/5/2000 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fuperal Service Licensee 22. Name and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one causa on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury as e consequence of) physician s the buria Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 88 USB signed by the signed by the signed f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, g The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 24 No 1 □ Yes 2 □ No Physician: director. Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 (XNatural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident 24 hours after deet Funeral Director: 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Hodicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifian completely (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 3 th (Item 23a) (Typ 21114 Paul S. Rhodes M.D., 1667 Crofton Center, Crofton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

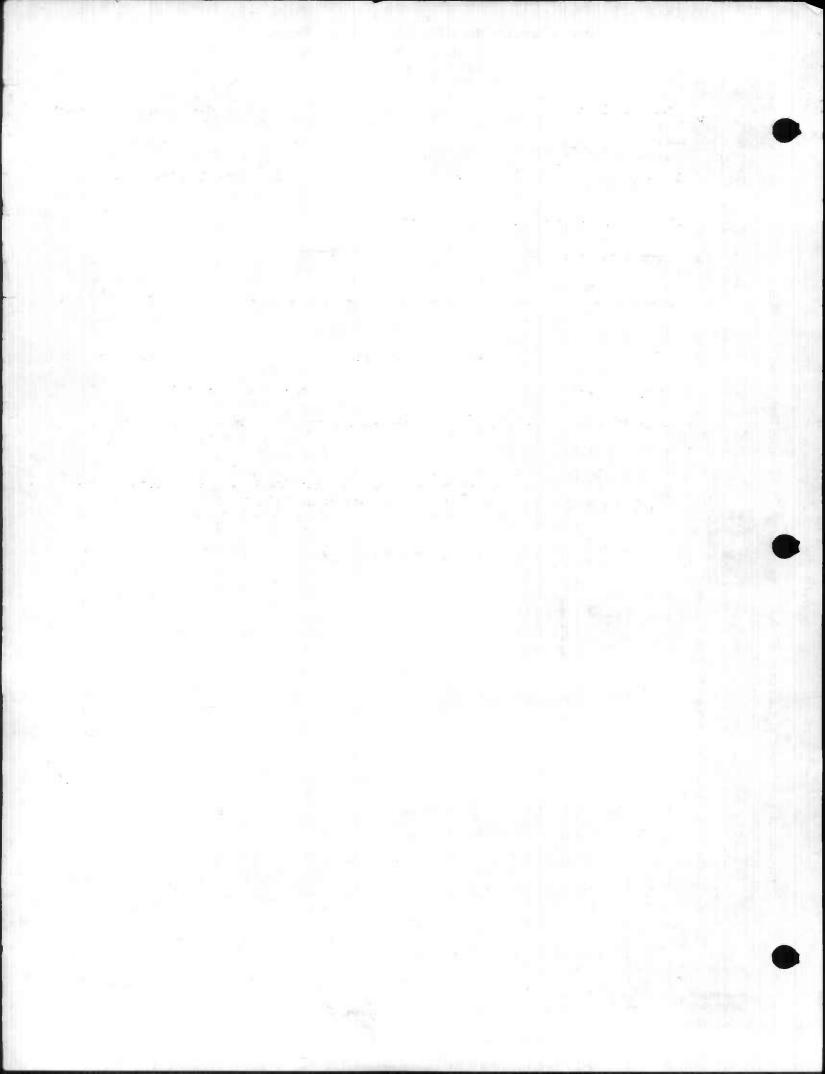
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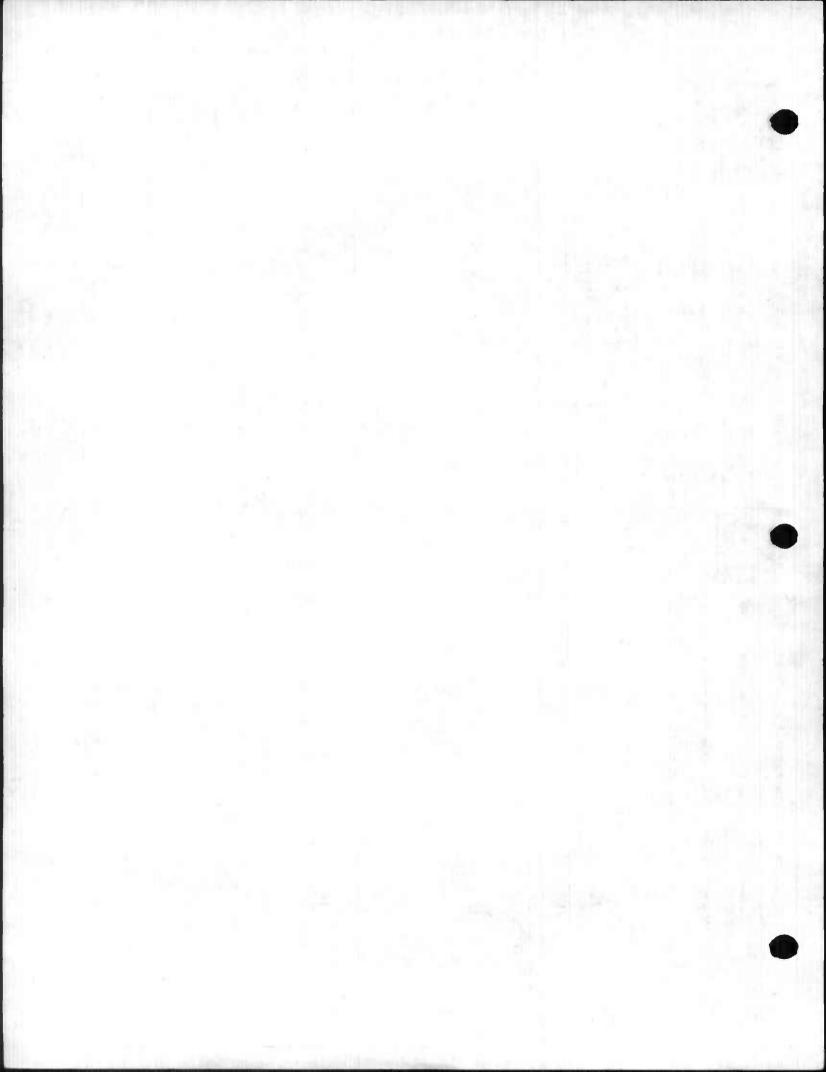
DHMH 16 Rev 6/95



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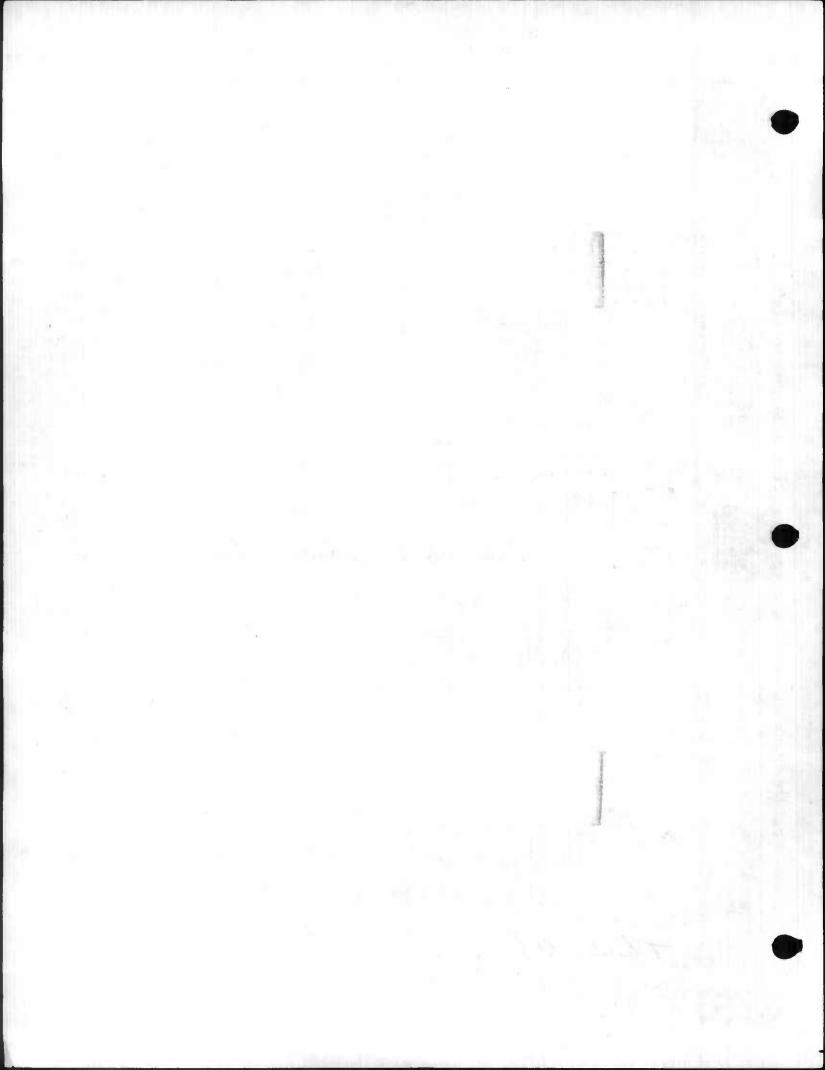
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Physician Medical Examiner    Physician Medical Examiner	UNE S	CHULTZ				-	Certificate of			Reg. No.	} 4	2571
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Baltimore, MD 21201    Physician   Physici	Pages nent of	ury or o	1 Donation	2 ☐ Cremation 3 ☐ 5 🕅 Other (Specification)	) in state	cemater		ace)	Data	20G. LOCATION	City of Tor	m, Stata
Physician (Macical Examiner    Due to (or as a consequence of):   Sequence of of other significant conditions, if any, leading to termediate cause. Enter Underlying in the limited events in the cause of death?   Due to (or as a consequence of):   Due to (or as	Bail Depart	any in	21. Signature of	Funary Service Licer	ade, Direc	ctor				Baltim	ore St	treet
Physician (Macical Examiner    Due to (or as a consequence of):   Sequence of of other significant conditions, if any, leading to termediate cause. Enter Underlying in the limited events in the cause of death?   Due to (or as a consequence of):   Due to (or as		-	23a, Parl1. Enta	r tha disease, or com	plications that caused	d tha death. Do r	not antar tha moda of dy	ing, such as cardiac	or raspiratory a	arrest,		Approximate
Cause (Disease or Injury that mistalization death of the cause of the cause of	/ /Med Exam	dical niner	disease or condi	tion	. art	Dua to (or as e		lors al	1 Ni	une		
The state of the s	'60, be execute	burial-trans	Sequentially list of any, leading to cause. Enter Un Cause (Disease	conditions, immediate derlying or injury	C	alo coso						
25. Was case referred to medical aximiner?    State	OX 687 certificate	use as the	resulting in death				1 1					
25. Was case referred to medical aximiner?    State	m a	d for	Pert II. Other sign	nificant conditions o	ontributing to death b	out not resulting In	the underlying causa o	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
25. Was case referred to medical aximiner?    State	P.O.	deteche y Phys										11
25. Was case referred to medical aximiner?    State	rds ulres	P P									24b. Wa	re autopsy findings
25. Was case referred to medical aximiner?  26. Place of Deeth (Check only one)  27. Manner of Death  1 Netural  28. Dete of Injury  28. Dete of I	0 2 3	sho							1	ormed?	con	pletion of cause
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and difference of person who completed cause at least (liter 23a) (Type, Print)  The water of the filed (Month, Day, Year)  21. Date filed (Month, Day, Year)  22. Registrer's Signature  23. Loans and due to the cause(s) and mannar as stated.  24. Loans and due to the cause(s) and mannar as stated.  25. License number  26. C.M.E.  26. License number  27. DECEMBER 14, 1999  28. Registrer's Signature  29c. License number  29d. Date signed (Month, Day, Year)  29c. Maryland 21201	ta E	to. p	25. Was case ref	erred to medical				26. Place of Dee	th (Check only	one)		74
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and difference of person who completed cause at least (liter 23a) (Type, Print)  The water of the filed (Month, Day, Year)  21. Date filed (Month, Day, Year)  22. Registrer's Signature  23. Loans and due to the cause(s) and mannar as stated.  24. Loans and due to the cause(s) and mannar as stated.  25. License number  26. C.M.E.  26. License number  27. DECEMBER 14, 1999  28. Registrer's Signature  29c. License number  29d. Date signed (Month, Day, Year)  29c. Maryland 21201	yalok Z	oerip O		□No	Hospital: 1 ☐ tnpatie	ent 2 ER/Ou	tpatient 3 DOA	ther			ner (Specify	)
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O.C.M.E. DECEMBER 14, 1999  30. Name and address of person who completed cause of meth (litem 23a) (Type, Print)  THE WORK M. K	DIVIS I or Atte	d in by th		determined	286. Place of this	ury - At home, fe c. (Specify)	rm, street, factory, office				ber or Rural	Route Number,
O.C.M.E. DECEMBER 14, 1999  30. Name and address of person who completed cause of meth (litem 23a) (Type, Print)  THE WORK M. K	24 hours	letely fills	(Check only	1 Certifying Ph	niner: On the basis of	axaminetion and	, deeth occurred et the t d/or invastigetion, in my	ime, date end place, opinion, deeth occur	, end due to tha rred at the time	cause(s) and m., data and place,	annar as sti and due to	nted. tha cause(s)
O.C.M.E. DECEMBER 14, 1999  30. Name and address of person who completed cause of meth (litem 23a) (Type, Print)  THE WORK M. K	vithin th	Me	29b. Signature ar	nd title of certifier	. /		29c. Licer	nse number		29d. Date signe	d (Month, C	Day, Year)
State 31. Date filed (Month, Day, Year) 22. Registrer's Signetury 12. Registrer's Signetury 13. Date filed (Month, Day, Year) 14. Registrer's Signetury 15. Registrer's Signet			MI	1	116:00	2.00	0.	C.M.E.		DECEMBE	ER 14,	1999
State 31. Date filed (Month, Day, Year) 82. Registrer's Signeture 10.00			30. Name and ad		0	anth (Item 23a) (	(Type, Print) nn Street,	Baltimore	, Maryl	and 2120	)1	
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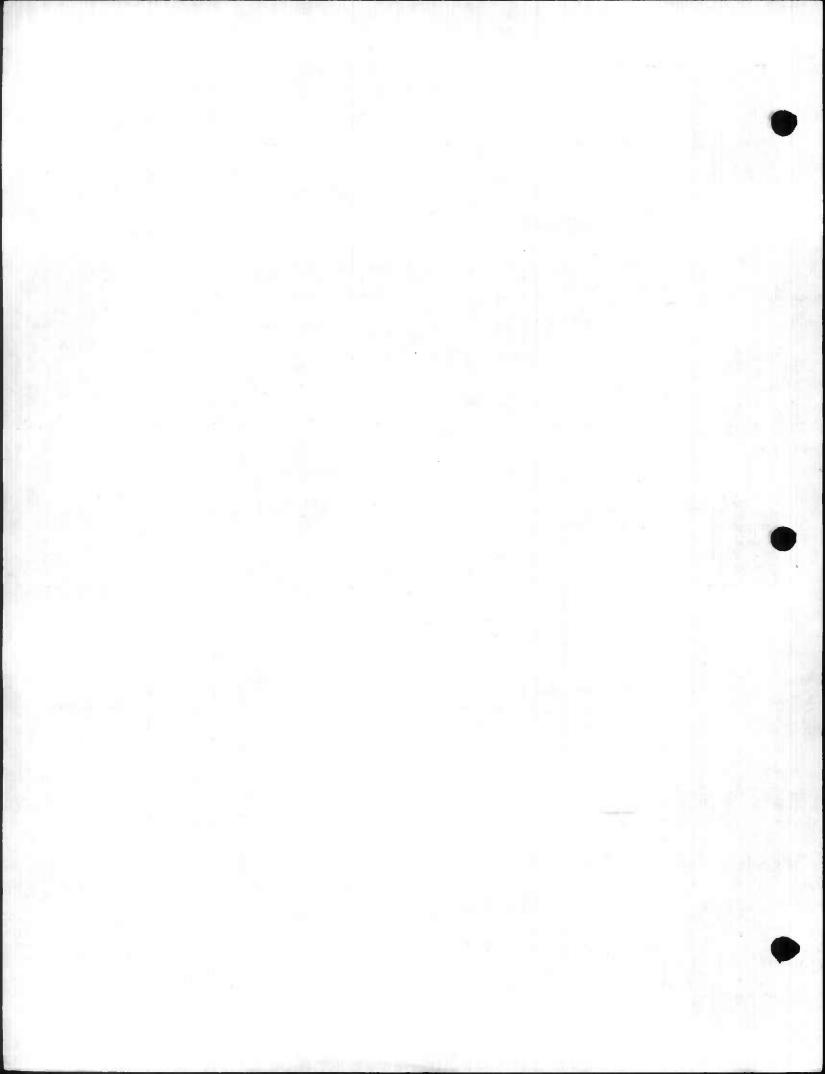
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #25 PER MD G779 1/19/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** December 26, 1999 15:51 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Sinai Hospital of Baltimore Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 9 Birthplac lace (State or Foreign **Funeral** 10 M 2 F Days Months 1-28-570 Director Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yaa 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Funeral 12, Was Decedant Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Meritel Stelus Black, Whita, etc. 1 Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 1□ Yes 2☑ No Specify by 3 ☑ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College-(1-4or 5+) d 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I Pages 1 and 2 should be 19a. Informant's Name/Ralationship (Type, Print) (Tendanght 19b. Mailing Address (Street and Number or Rural Royte Number, Department of Health a Important: If Item 27 is any injury or other tra 20a. Method of Disposition 20b. Piace of Disposition (Nama of cemetery, crematory or other) Dete 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from Stete 4 Donation 5 □ Other (Specify) 22 Nama and Addrass of Facility 21. Signature of Funaral Sarvice Libensee Ku er oseph North 22 Ave 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition rasulting in death) Pneumonia 2 weeks Examiner Dua to (or as a consequence of): Examine Multiple Cerebrovascular Accident 10 years physician and the burial-trans Dua to (or es e consequence of): Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury Chronic Aspiration Box 68760. Physician/Medical that initiated evants rasulting in death) Last Due to (or as e consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Hypertension page 2 : The 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only one) Yas ex Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Attending 5 Pending invastigation 1 ☐ Yes 2 ☐ No n 24 hours after deeth le Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be detarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - Al homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 6 29a. Certifian edicai 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatura and titla of certified 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Greenspring Ave. Ste301, Baltimore, m) 2/2/1 O. LAWOYIN, M.D. DLUSEGUN 3901

**DHMH 16 Ray 6/95** 

State Registrar 31. Data filed (Month, Day, Year)

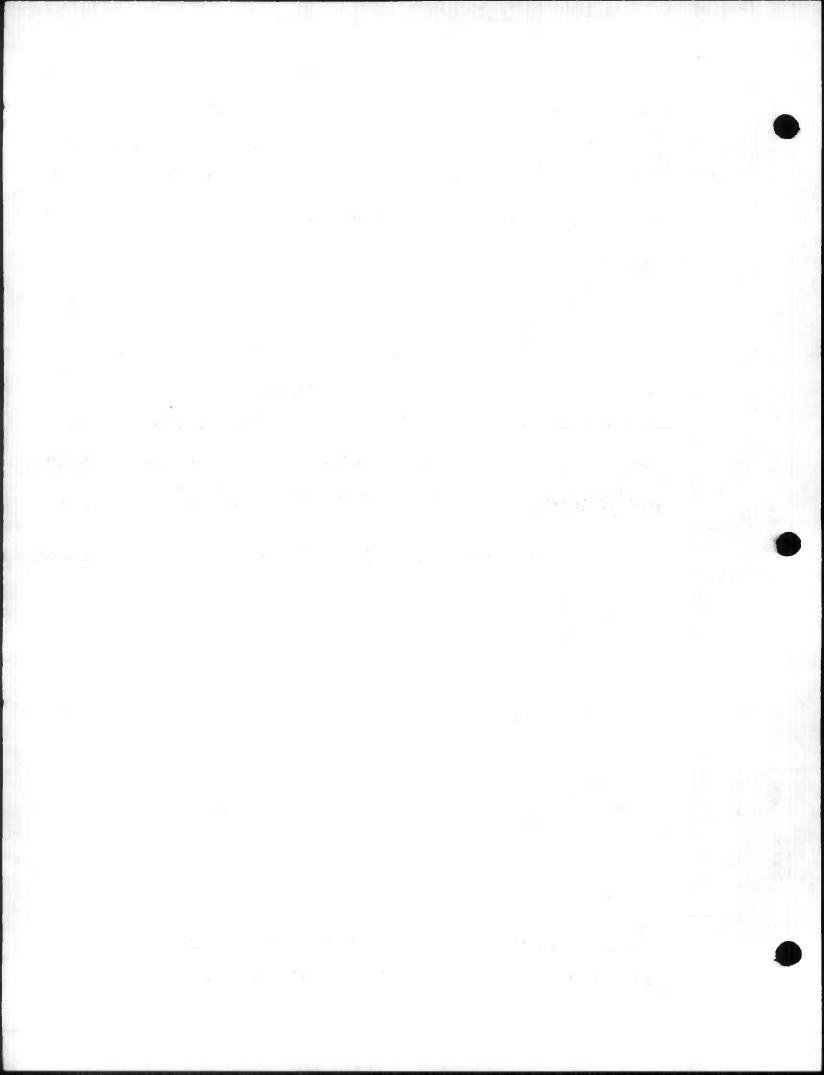
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State of Maryland / Department of Health and Mental Hygiene 99 1.2

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Н	Physic	ian	Decedent's Name (First, Middle, Last						Date of Dea     Month	Dev	Year	3. Time of Deat	
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	Funeral Director		5. Social Security Number 6. Se 461-74-2048  Usual Residence of Decedent	X 7. Ag	53	Yrs. If U	nder 1 Yaar ths Days			v. Year)	Coun	place (Steta or Fore stry) JSTRALIA	aign
	yland		10a. Stata 10b. County 10c. City, Town or Location								1	0d. Inside City Lin	nits
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	or 28	Director	10e. Street end Number			101	. Zlp Code	The View		10g. Citizen of	Whet Coun	itry?	
	1 wit		20716 TOWNSEND ROA	AD			2	21779		II.	S.A.		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,	S. 13. Was D		Hispenic Origin? (S an, Mexican, Puer	Specify Yes or No-	14. Rac	e - Americ		
21215-0020	within 72 hours after death with the Maryland liene. 't than "natural', or items 23a or 28a-f show The Medical Examinat must be notified at	by	1 ☐ Never Marriad 2 ☑ Marrled 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		specify Cub		to Hican, etc.)	Specify	ck, White,	atc. JHITE	
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest gred			16a. Decedent's	Usuel Occup	pation	dia	16b. Kind of B			
21	5 2 3	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NO	T use retire	during most of wo	rxing				
	filed within Hygiene. ther than " int, the Mo	Co		3		RADIOLOG1	CAL I	ECHNOLOG	IST	НО	SPITA	L	
pu	a la b	Be	17. Father's Name (First, Middle, Last)		18. Mother's			18. Mother's Na	me (First, Middle,	Meiden Sumen	70)		
Maryland	should nd Men marke	2	WILLIAM LEWIS ARNI	.CAR				MAUREEN	W. FITZ	• FITZPATRICK			
Var	d 2 should h end Mer 7 is marke traumatic		19a. Informent's Name/Reletionship (T)			19b. Meiling Add	iress (Street	end Number or R	urel Route Numbe	er, City or Town,	Stete, Zip	Code)	
	CENL		DIANE T. ARNICAR/S	POUSE	1			D ROAD,		MARYLA		21779	
0	1 0 0 T		20e. Method of Disposition 1 ☐ Burlal 2 ☒ Cremation 3 ☐ F	Removel from State	20b. Pl	ace of Disposition matery, cremetory	(Neme of or other ple	ce)	Date	20c. Location -	City or To	wn, State	
Baltimore,	men men mant: lury		4 ☐ Donation 5 ☐ Other (Specify)		SMI	THSBURG	CREMAT	ORY 1	2/30/99	SMITHSE	BURG,	MARYLANI	)
Sal	permit. Pag Depertment Important: If any injury o		21. Signature of Puneral Service Doens			1	e and Addre	ess of Facility					
ш	20239		Paul M. Dean BAST FUNERAL HOME 7606 Old National Pik Boonsboro, Maryland										
			23e. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.										-
V)	Physician											Interval Between Onset end Death	
4	/Medical Examiner		Immediate Cause (Final disease or condition	ncer	2 years								
	Examino	Ļ	resulting In death)		Due to (or	es a consequence	of):						
	Pa iz	Examiner		0. ————							I		
	the death certificate be executed by the attending physician end sched for use as the bunal-transit	xan	Sequentially list conditions, if any, leading to Immadiate		Due to (or	as e consequence	of):						
09	be e lcian buna	<u>a</u>	Ceuse (Disaase or Injury	S									
68760,	ifficate ig physics sthe	edical	thet initieted events resulting in death) Last		Due to (or	es e consequence	of):						
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o.	that the de sed by the a deteched	ıysı	Part II. Other significant conditions cor	*	ut not resu	lting in the underlyi	ng ceusa gh	ven in Part I.				the cause of dea	
۵.	that ed b		Preumone						101	fes 2□ No	3 Prob	bably 4 Unkn	own
of Vital Records,	5 50	d by							24e Wes	an autopsy	24b. Wa	are eutopsy finding	28
Ö	v require been si should I	Completed								med?	909	elleble prior to impletion of ceuse	
Re	The lay ete hes page 2	m d								_/		death?	
ā			25 Was cose referred to medical						1 U Y		1L	Yes 2□ No	
5		o Be	25. Was cese referred to medicel examiner?	lospital:			Ott	nor.	eth (Check only o				-
	Physic rthis ral dir	-	27. Manner of Deeth	1 ☐ Inpatie		ER/Outpatient 3 28b. Time of	DOA	4 Li Nursing r	ome 5 Resid			"	
o	ding th. After	tior	1 Natural 5 Pending 2 Accident investigation	(Month, De)	Year)	Injury	28c. Inju Wo	rk? Yes 2 □ No	200. 2000.00	on injury occur	.00		
Division	or Attending effer death. Director: After d in by the fune	Certification:	3 ☐ Sulcide 6 ☐ Could not be	28e. Place of Init	28e. Place of Injury - At home, farm, streat, factory, office		28f. Location (Street and Number or Rural Routa Number,			l Routa Number			
É	offer of or din the	ert	4 ☐ Homicide determined	building, efc			,,		City or Tow			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Hospita 14 hours Funeral tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of and menner sta	examinati	rledge, deeth occur on and/or Investiga	red et the ti	me, date end place opinion, death occu	e, end due to the curred et the time, c	euse(s) end me date end place,	enner as st and due to	ated. the cause(s)	
	within 2 To the comple	Me Me	29b. Signetuça and title of certifiar				29c. Licens	se number		29d. Date signe	d (Month, i	Dey, Year)	
	- s - 0		1 Demy 2				04	4996		Dec	30	1999	
			30. Name end eddress of person who co	mnleted cause of d	eeth /ltem	23a) /Tuna Brint)					,	// //	
			Zafar Malik	Mp		0 3/1 La	ppan	4996 s Roa	Bon	resoro	M	0217/3	
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registra	ar's Signet		1			-			-



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #5 PER F.H. G779 1-31-2000 WR. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Helen Virginia 12/40 hrs Adkins 4b. City, Town, or Location of Death 24c. County of Deeth /Medical 4e Fecility Name (If not Institution, give street and number) Examiner Chestertown
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) Chestertown Nursing & Rehab. Center tf Undar 1 Yaar Birthplace (Steta or Foraign
Country) 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2XF Months Deys 94 Yrs. February 14, 1905 Rock Hall, Maryland **Director** Usuet Residence of Deceden Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland nent of Health and Mentel Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examinat Intel the notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 415 Morgnec Road 21620 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2XXNo Specify: White þ 34 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Coltega (1-4or 5+) Own home Homemaker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) William Williams Unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Margaret Adkins/Daughter-in-Law 310 S. Joplin Street, Baltimore, Maryland 21224 20b. Pleca of Disposition (Nama of cametery, crematory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Deta Department of Important: If it any Injury or o 1 ABurlet 2 Cremetion 3 Removel from Steta 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cemetery 12/28/99 Rock Hall, Maryland 21. Signeture of Funeral Servica Licansee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23e. Perti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, tnterval Between Onset and Death **Physician** · CEREBROVASCULAR ACCIDENT Immediete Ceuse (Finel diseese or condition rasulting In daath) /Medical 3 wks Examiner CARDIO VASCULAR DISEASE >10 yrs Examiner HYPERTENSIVE physician and the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Ceuse (Diseese or Injury thet Initieted evants rasuiting in daath) Last Dua to (or as a consaguance of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as e consequenca of) for use es 80 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed is certificate hes I 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was casa rafarrad to medical axeminer? Be 26. Placa of Daath (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar es stated.

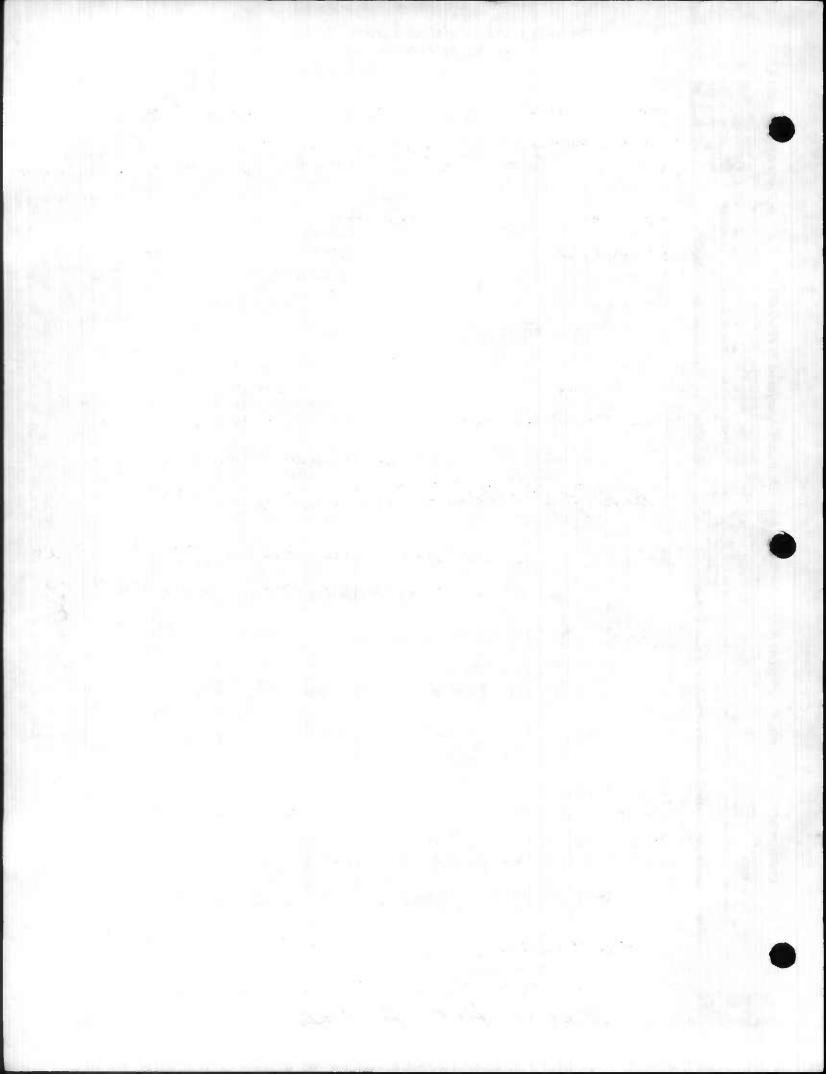
2 Medical Examiner: On the best of axamination and/or Investigation, in my opinion, death occurred at tha time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number D41587 5

State Registrar Helen A. Noble 122 Speer Road, Suite 5, Chestertown, Maryland 21620
31 Date filed (Month, Day, Year) 32 Registrar's Signature

30. Neme and eddress of person who complated cause of death (Itam 23a) (Type, Print)

DEC 28

B. Spark



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Malcolm December 24, 1999 Anderson 4:44 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Director Jan 2, 1922 Maryland 215-18-1083 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. toside City Limits r 28a-f show a notified at 1 ☐ Yes 2 No Directo Adamstown Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 'natural', or Items 23a or United States 21710 2779 Adams Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 US Gov't Lab Tech 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental Important: If Item 27 is marked of any Injury or other Charles C. Anderson Merriman Nina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 2779 Adams Street, Adamstown, Md Betty Anderson / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/99 Frederick, Maryland Olivet Mausoleum 22. Name and Address of Facility
Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licent 21702 1621 Opossumtown Pike, Frederick, MD locations that caused the shath. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each one. 23a. Part . Enter the disease shock, or heart teilure. Approximata Interval Between Onset and Death **Physician** 2-3 /Medical Immediete Cause (Final · Respiratory Failure disease or condition resulting in death) Weeks Examiner several Examiner Asthma that the death certificate be axecuted physician and as the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760 several days orgestive heart taulure Physician/Medical Due to (or es e consequence ot): fair several ure) acute and chronic months Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown been signed by should be detac vasculitis cirrhosis, anemia Records, 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy completion of cause of death? page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case reterred to medical axaminer? 86 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 DInpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. injury at Work? After 5 Panding investigation 1 Netural i hours after death. uneral Director: After ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled: Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ture and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20h Sid 10054709 12 25 99 and address of person who completed cause of deeth (Item 23a) (Type, Print) Katherine Buki

**DHMH 16 Rav 6/95** 

State Registrar 300 West

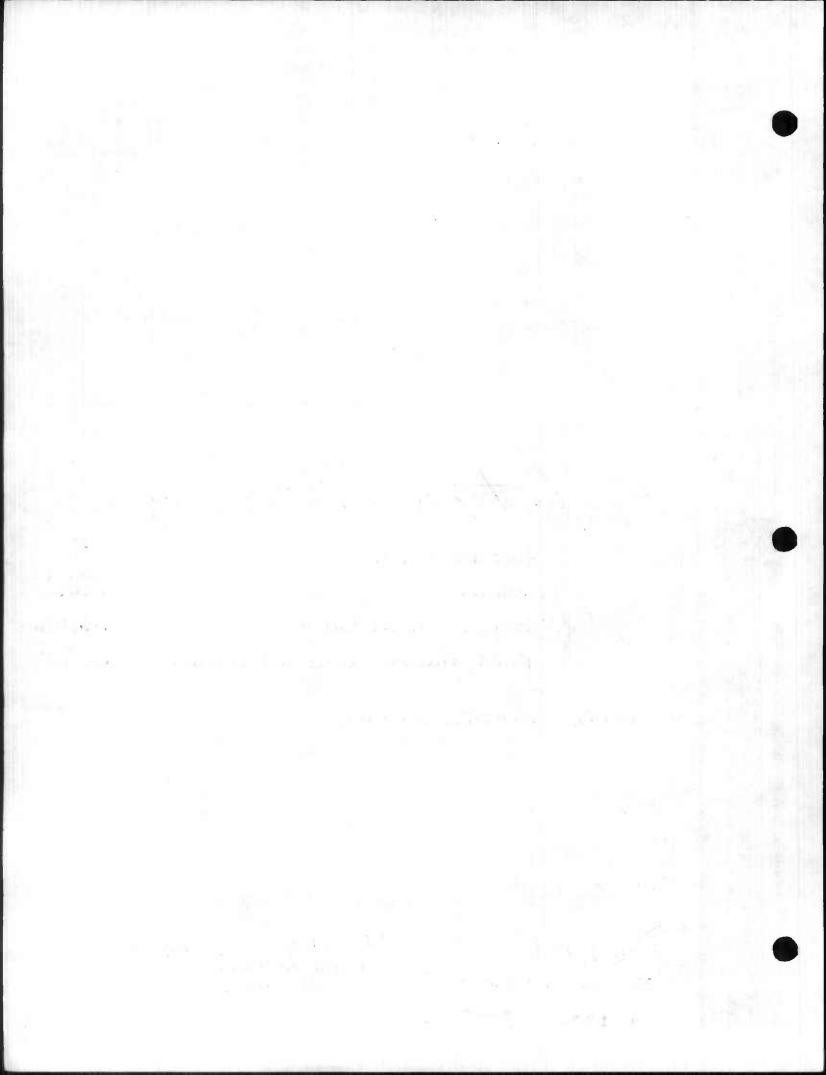
31. Date filed (Month, Day, Year)

Frederick

MD 21701

greet

32. Registrer's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** 3:08 pm nau December dr. 1999 John /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ashington Washingt COUNT If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** Months Days 48 4209 1 XM 2□ F Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow traumatic avent, the Medical Examiner rount be notified at 1 ☐ Yes 2 No Funeral Director 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Nems 23s or Kaga 217 S death v 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Manital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Meniel Hygiene. Important: If Hem 27 is marked other than "natural", or Health and Meniel Hygiene. 1 Never Merried 2 Married 2 X No 1□ Yes 2D No Specify Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hagerstown Elemantary/Secondary (0-12) College (1-4or 5+) spatch 18. Mother's Name (First, Middle, Maiden Surhame) 17. Father's Name (First, Middle, Last) Binac Florence Moble P OPINSON 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town State, Zip Code) Shapiro Smithsburg, MD 21783 20b. Plece of Disposition Nema of cemetery, cremetory or other plece) ousan, 20c. Location City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Ramoval from Steta Frederick, MD sthakn 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Sarvice Licensee 22. Name and Address of Facility Zumbrun Faneral Home Sykesville umbrun Sykesville MD 21784 6028 23a. Perty Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest pshock, or heart feilure. List only ona ceusa on each line. **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of) 0% Physician/Medical Examiner 01 attending physician and for use as the burial-transit Sequentially list conditions, If any, leeding to immediate cause. Enter Undarlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) De execu Records, P.O. Box 68760, INJUICA Due to (or as a conseque ate has been signed by the atte-page 2 should be detached for Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? No No 3 Probably 4 Unknown 1 Yea Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? or Attending Physician: director, 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this funeral 27. Menper of Deeth 28b. Time of fnjury 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Division Netural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide

State Registrar

completely

29e. Certifier

(Check only one)

29b. Signature and title of gertifie

Hospitai

To the

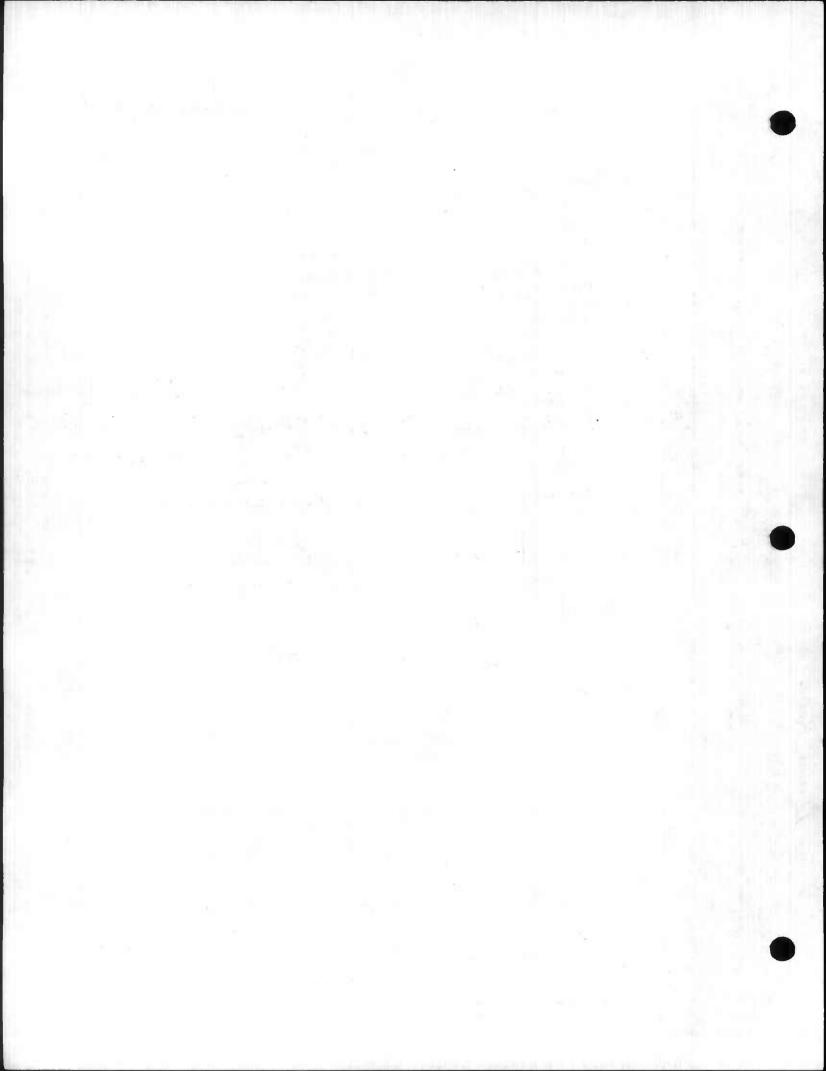
Binau, Robert

eth (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

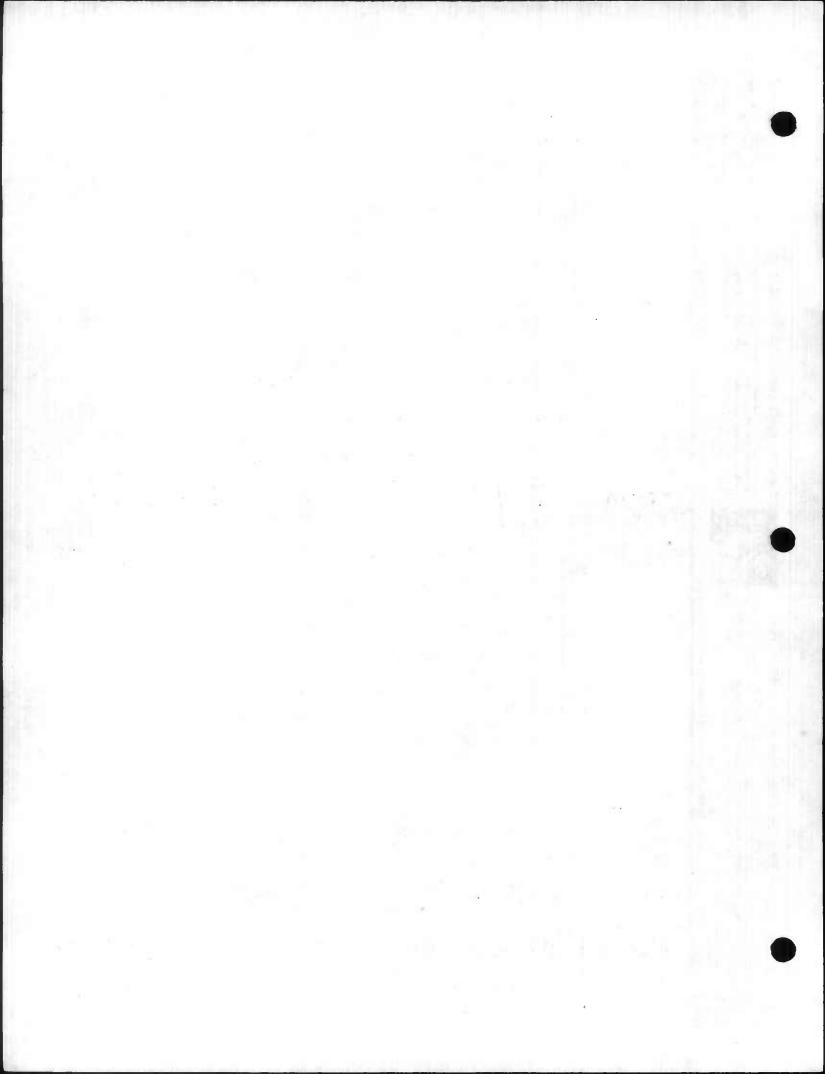
29d. Date signed (Month; Bay, Year)



State of Maryland / Department of Health and Mental Hygiene Q

Physician	1. Decedent's Name (First, Middle, Last					2. Date of De Month December	Day Y	3. Time of Deal	
/Medical Examiner	Ab City Youngeloo								
LAdililie	9716 Masser Ro	:k	Frede	erick					
Funeral Director		7. Age (In yr. 85	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Monte, Pa April	1, 1914 M	Birthplace (State or For Country) laryland	
ž	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  The description of The description 10c.								
tor tor	Maryland Frederic	ek E	rederic	k				1 □ Yes 2	
obstruction 23e or 23e-fail obstruction be pounded Funeral Director	10e. Street and Number 9716 Masser Road	I		10f. Zip Code 21	702		10g. Citizen of Wha		
by	11. Meritel Stetus  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		/es Decedent of H Yes, specify Cub	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. White	
	15. Decedent's Edu (Specify only highest grad			ent's Usual Occup cind of work done O NOT use retire eral Con	pation during most of work d) tractor	ing	16b. Kind of Busin		
other than event, fre the Be Comp	17. Father's Name (First, Middle, Last)		- OCII	CIGI OUI		e (First, Middle,	Maiden Sumame)	CIOII	
	George Fra	ncis Baker			Grace	Virgin	ia Harri	et Hoffman	
7 le me Traum	19a. Informent's Name/Relationship (Ty Shirley A. Johnson	on, Niece	9716	Masser			er, City or Town, Sta Maryland		
ment of flesh 2 ury or other	20e. Method of Disposition  12 Burial 2 Cremetion 3 P  4 Donation 5 Other (Specify)	lamoural from State		atory or other ple	y, Dec. 20,	Date 1999	20c. Location - City Frederic	y or Town, State k, Marylan	
Important: If eny injury or page.	21. Signature of Funeral Service Licensee  MO0255  22. Name and Address of Facility. Keeney and Basford P.A. Funeral Ho 106 East Church St., Frederick, Md								
ysician	23a. Pert1. Enter the disease, or compl shock, or heart feilure. List only or	icetions that caused the de ne cause of each line.						Approximate Interval Betwee Onset and Deat	
Medical aminer	Immediate Cause (Final disease or condition resulting in death)  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):							1997	
it Iner		Pulmo		1997					
os the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		(or as a consequant	rtic Ane	urysm			1998	
00	that initiated events resulting in death) Last	Due to (or as a consequence of):  Dysproteinemia						1998	
d for u	Part II Other significant conditions con	stributing to death but not re	eulting in the un	domina cousa ai	ton in Part I	23h Did	23b. Did tobacco use contribute to the cause of		
igned by the attending be detached for use by Physician/M	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Chronic Renal Insufficiency  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.								
director, page 2 should be forestor, page 2 should be forestor.		T				24a. Was	an autopsy 2 ormed?	4b. Were autopsy finding available prior to completion of causof death?	
page Com						10	Yes ZONo	1 ☐ Yes 2XXVo	
ector.	25. Was case referred to medical examiner?	doenital:		low	26. Place of Deal				
三	1 ☐ Yes 2 X Yo  27. Manner of Death	28a. Date of Injury	ER/Outpatient	3□ DOA OII 28c. Inju Wo			dence 6 Other (	Specify)	
sel Director: After tied in by the funera	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year)  28e. Place of Injury - At	Injury	M 1	rk? Yes 2 □ No	28f. Location (	Street and Number of	or Rural Route Number,	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier XXCertifying Physics	building, etc. (Special Control of the best of my kn	cify)		me, date and place	City or To	wn, Stete)		
he Funer pletely fill edical	(Check only 2 Medical Examinations)	ner: On the basis of examinand manner steted.	nation and/or inv	estigation, in my o	pinion, death occur	red at the time,	date and place, and	due to the cause(s)	
To the	29b. Signature and title of certifier	11/	nan.	29c. Licens			29d. Date signed (A	and the state of	
	Michael y	· ylon,	YVW	D 41	717		December	20, 1999	
	30. Name and address of person who co	, M.D., 186							

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JULIA VIRGINIA BABCOCK DEC. 26,1999 0950 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MAGNOLIA CENTRE LANHAM PRINCE GEORGES If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20 F Months Yrs. 579-09-1724 Director AUG. 31,1904 Maryland Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show "netural", or iteme 23e or 28e-f show 1□Yes 2□No MD. Prince Georges Director Lanham 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? 8200 Good Luck Road 20706 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours effer deeth nent of Heelth and Mentel Hyglene.
wit; if Hen 27 is marked other than "natural", or flame 28 iry or other treumatic event, the final feature me mainty or other treumatic event, the final feature me mainty or other treumatic event, the final feature me mainty or other treumatic event, the Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk/Secretary Federal Covernment Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum Christian Schade Clementine Virginia Runkles 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Schade (Niece) 5514 Old National Pike, Frederick, Md. 21702 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or pates. 4 Donation 5 DOther (Specify) Mount Olivet Cemetery 12/29/99Frederick, Maryland 22. Name and Address of Fecility
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. Frederick, md 21701 Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such es cardiac or respiratory errest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical ASYSTOLE 15 mu. Examiner Physician/Medical Examiner INFARCTION MYOCARDIAL hour physicien end the burlel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ARTERY DISEASE Box 68760. ORRO WARY YEAVS 8 HEART DISEASE THEROSCLEROTIC Years 995 signed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use cogtyfbute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSIVE HEART of Vital Records. δ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Status Post Cardiac comaker completion of cause of death? Cerebrovascular Accident 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1118 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Affect Division 1 DiNatural or Attending 5 Pending investigation a Funeral Director: After Selector: After Selector After Selector 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) à 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely !! (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of curtil D22549

State Registrar

**DHMH 16 Rev 6/95** 

6510 Kenilworth Ave. Riverdale, MD.

32. Flegistrage Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

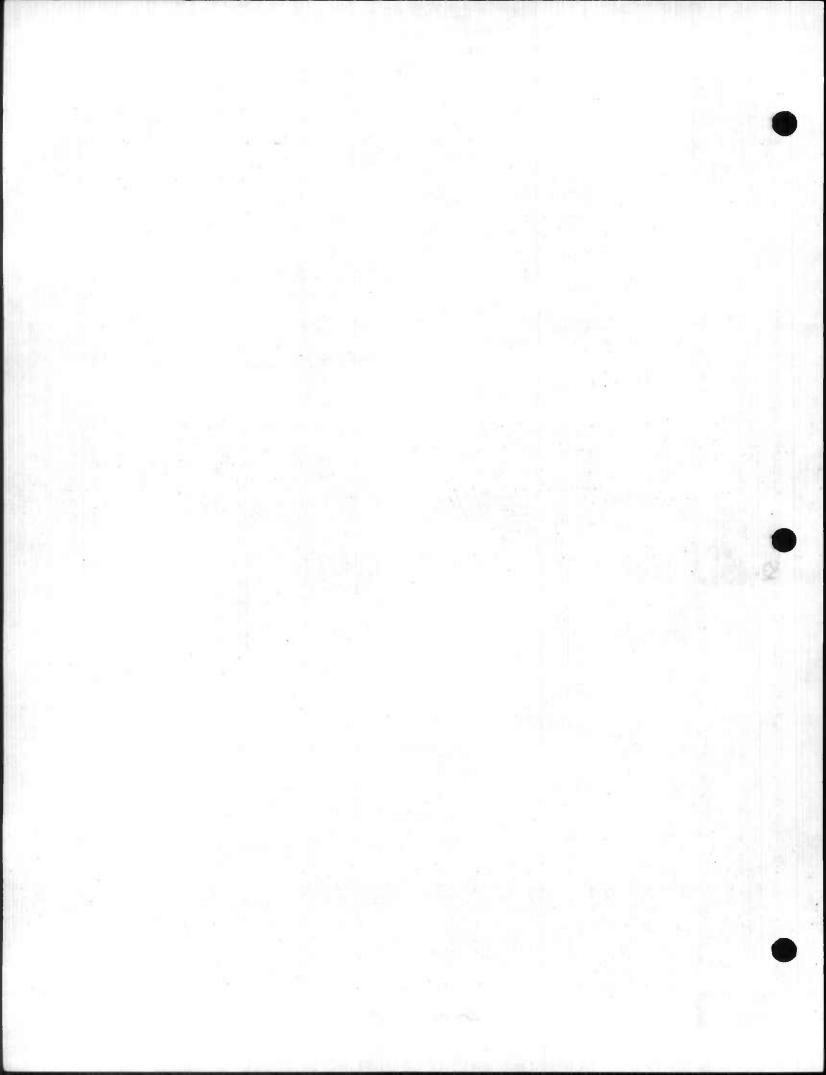
DEC 3 0 1999 >

G. M. Din, MD

31. Date filed (Month, Day, Year)

December 26, 1999

20737



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death December 27, 1999 Year **Physician Black** 12:50 AM Webster George /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Center Walkersville Frederick 8. Dete of Birth (Month, Dev. Year) Feb. 22, 1921 If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** N 2□F Hours 215-26-8399 78 Maryland Director Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yes No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9016 Bethel Road 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
\*\*TXYes 2 | No
#Yes, Give
Year or Dates: 1945—1946 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Merital Status 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1□ Yes 2□No Baltimore, Maryland 21215-0020 Specify: White ğ 30XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementery/Secondary (0-12) 12 College (1-4or 5+) Maintenance US Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: §1 tem 27 is marked offer any injury or other treamedic event, obdes. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Charles Vernon **Black** Marian Augusta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Mr. Dennis L. Hoffman, Son 12445 Catoctin Furnace Rd., Thurmont, Md. 21788 20b. Place of Disposition (Name of cemetery, cremetory or other p 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Resthaven Memorial Gardens, Dec. 30, 1999 Frederick, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Keeney and Basford P.A. Funeral Home M00255 106 East Church St., Frederick, Md. 23a. Pert1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on sech line. Approximate Interval Between Onset and Deeth **Physician** Careman To Brein : Pring linker Immediate Cause (Final disease or condition resulting in death) /Medical Som Examiner Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 20 No signed by 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings aveitable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? certificate has 1 Yes Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA this To the Hoapital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of De 28b. Time of 28c. Injury at Work? Neturel Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) December 27, 1999 30. Name and address of person a ed cause of death (Item 23a) (Type, Print) REDERIC

**DHMH 16 Rev 6/95** 

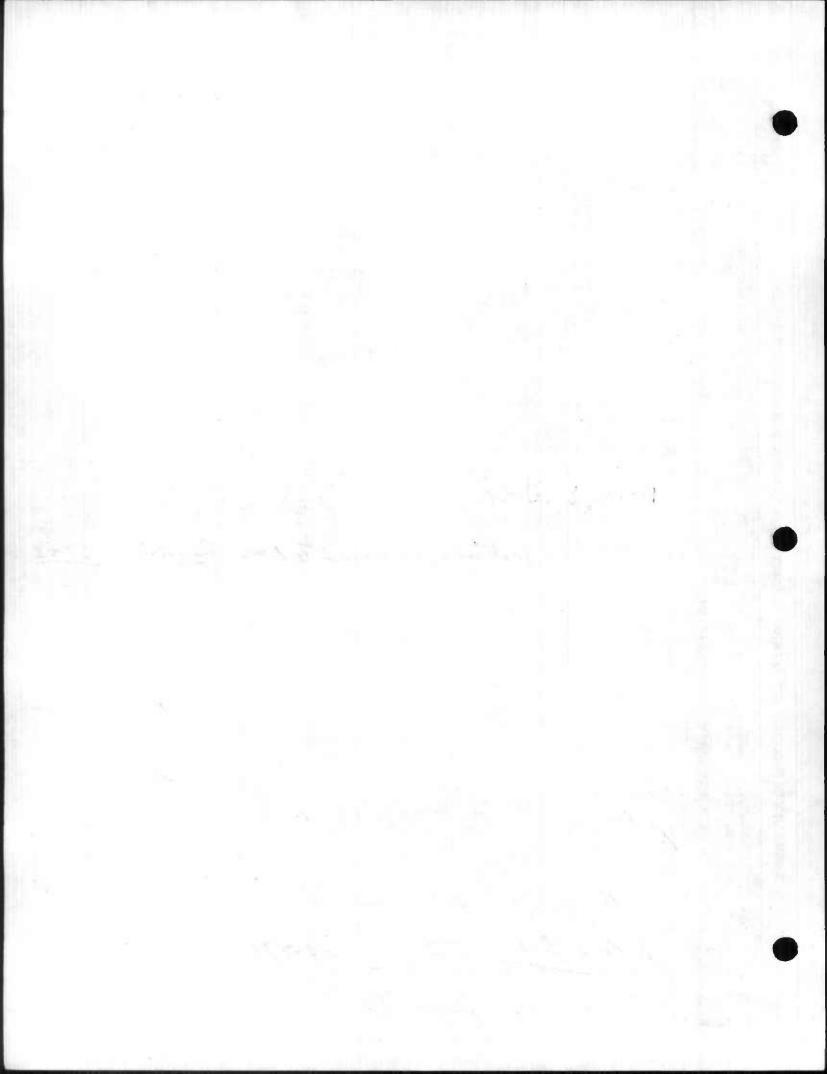
State

Registrar

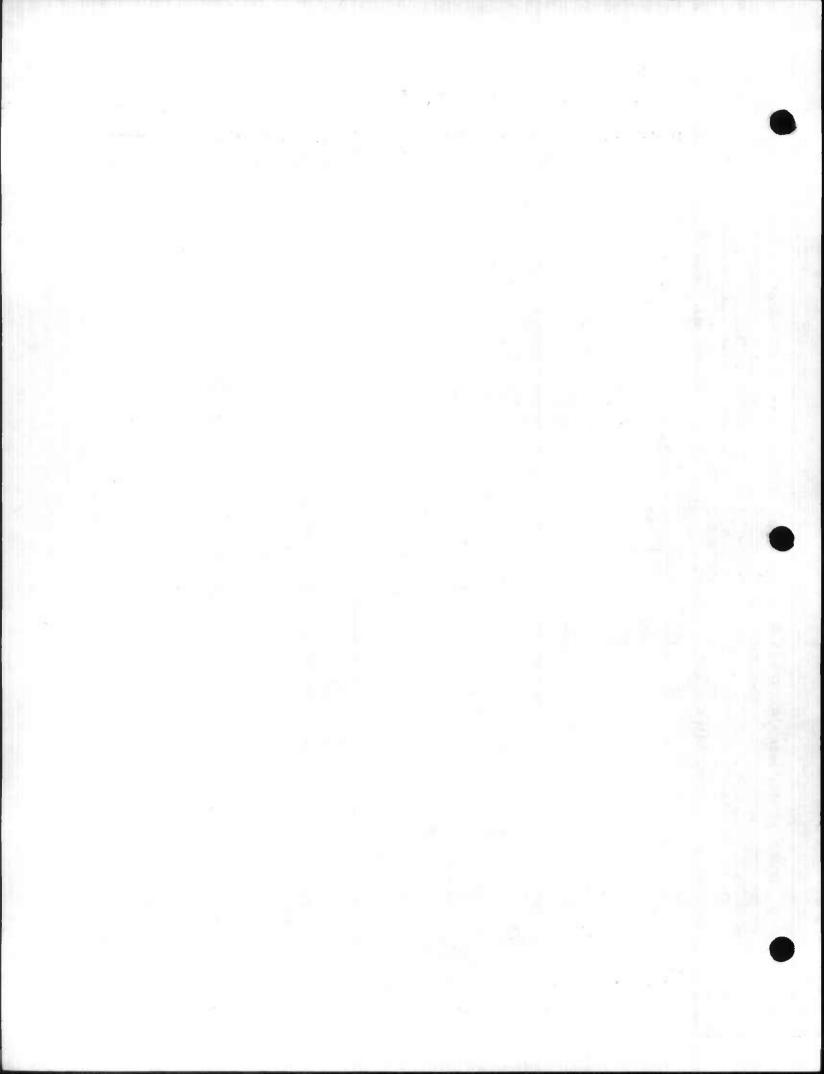
31. Dete filed (Month, Da

32. Registrar Signature

1999



State of Maryland / Department of Health and Mental Hygiene 0 42580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month BURDET 35pm **Physician** (OAVIN 1 ANE 12 4c. County of Beeth /Medical 4b City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) Examiner OF MARY LAND MEDICAL SYSTEMS BALTIMORE CIT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foreign Country) Maryland 7. Age (In yrs. last birthdey) **Funeral** 1**X** M 2□ F Yrs. 216-55-6754 **Director** July 7. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? ŏ herns 23a 560 Hollyberry Way 21703 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: altimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 0 Infant 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fill.
Department of Heelth and Mental Hy
Important: If Item 27 is marked oth
any Injury or other traumatic event Be John Richard Burdette, Jr. 2 Hope Elaine Bentz 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John Richard Burdette, Jr., father 560 Hollyberry Way Frederick, Maryland 21703 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete tXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Olivet Cemetery 12/31/99 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Fundral Service Licente 1621 Opossumtown Pike Frederick, Maryland 21702 Approximete Interval Between Onset end Death enter the mode of dying, such es cardiec or respiretory errest, **Physician** /Medical Immediate Ceuse (Final mos disease or condition resulting in death) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted evants resulting in deeth) Lest and 2 mos Milmona Box 68760 Physician/Medical the Due to (or es a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No à 3 Probably 4 Unknown 1 Yee signed be del Records, à 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was cese raferred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: Naturel 5 Panding investigation after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be datamined 28e. Pleca of Injury - At homa, ferm, straaf, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) hin 24 hours after de the Funeral Directo npletely filled in by ti 4 - Homicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) niner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. To the Vithin 2 29b. Signature and title of 29d. Dete, signed (Month, Dey, Year) leva-ms 30 Nama and addrase of person who complated cause of death (Ham 23a) (Type, Print) Haryla & Medical Systems: 225. Greene St SUSAN J. DULKERIAN, MD; UNWILL BY of Haryla & Medical Systems 225. Greene St BALTMORE, MD. 21201 32. Registrar's Signature 31. Dete filed (Month, Dey, Year) State JAN 03 2000 D Registrar

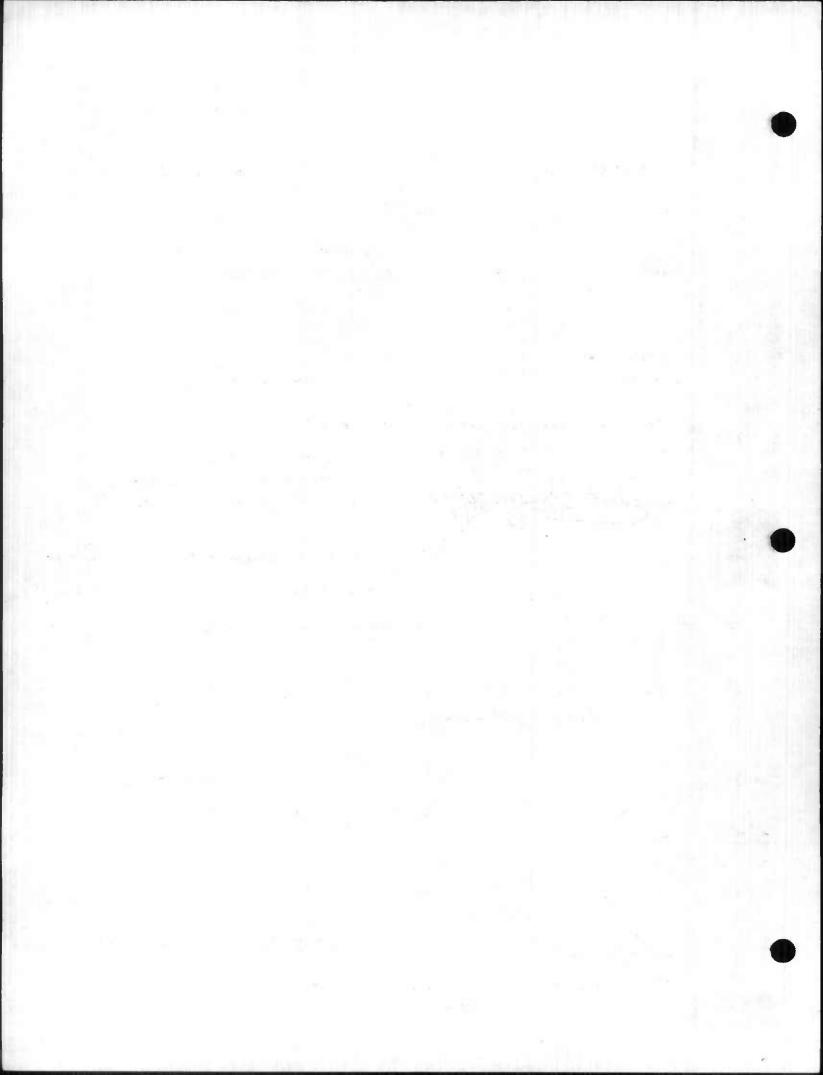


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician MARIE LESLIE DEC. 31, 1999 0350 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Frederick Health Care Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Manth, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months 219-52-1089 Yrs. 93 Director Mar 15, 1906 Virginia Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Frederick Frederick 1X Yes 2 No Director 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a or 30 North Place 21701 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Rema 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.

sert: It flem 27 is marked other than "natural", or its any or other traumatic event, the Medical Examins 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10th Farming Farming 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Jack Butler Dorsey Burten 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) Gilbert A. Berry, Sr. Husband 2808 Raleigh Road Walkersville, Md. 21793 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory 12/31/99 Smithsburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Lice Robert E. Dailey & Son Funeral Homes, P.A. 1201 N. Market St. Frederick, Md. 21701 23a. Pert1 Enter the diseese, or con eth. Do not enter the mode of dying, such as cardiec or respiretory arrest, **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Box 68760. physician Physician/Medical the Due to (or as e consequence of): deteched for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 20 No 2 3 Probably 4 Unknown signed to Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: Nursing Home 5 Pasidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) eg. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certify 29c. License number D47556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. JOhnson, MD 172 T.J.Drive Frederick, Md. 21701 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State 0 4 2000 Registrar



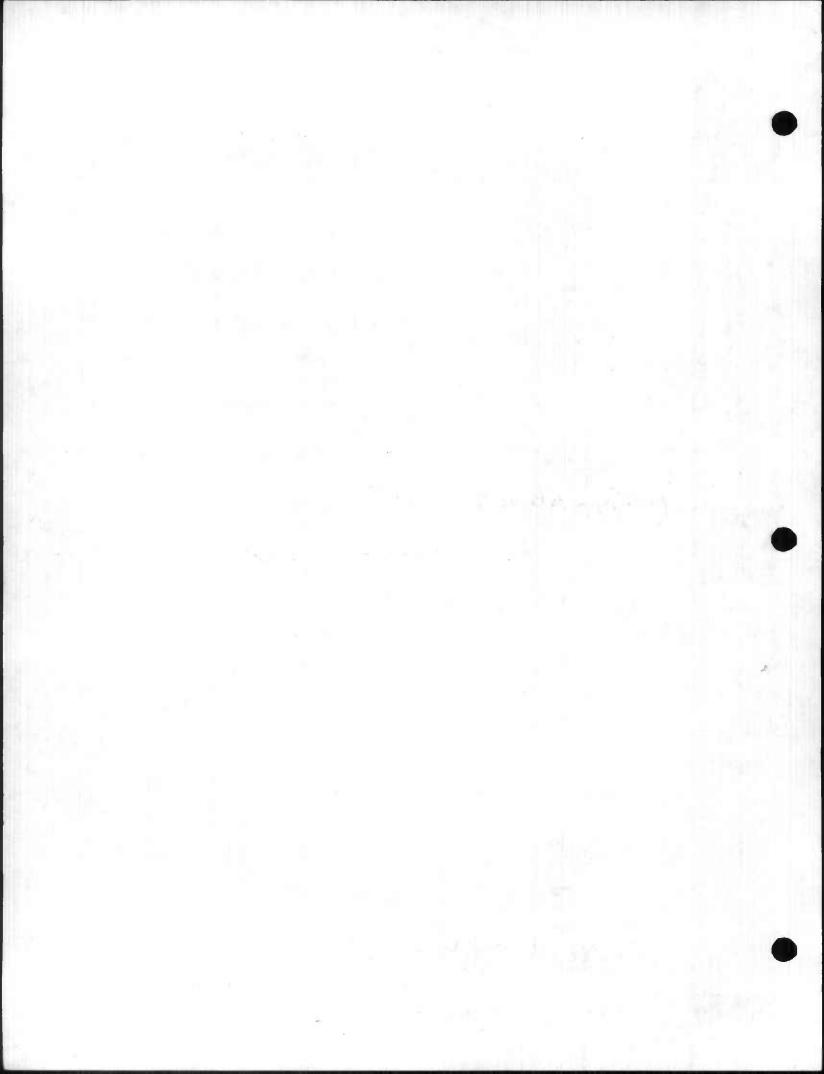
State of Maryland / Department of Health and Mental Hygiene QQ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death 31, 1999 Month **Physician** Suzanne Lee Bunitsky December 5:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5400 Holiday Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 20, 1952 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 47 Yrs. 219-54-8029 Washington, DC Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show Frederick New Market Maryland 1 Yas 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 6897 Meadow Point End 21774 U.S.A. Funeral Nerte 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, Whita, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 8 White 1 Yas 2 XNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home altimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 ahould be in ment of Health and Montal H ant: If them 27 is marked off lury or other traumatic even Be Otis Edward Johnson Jane Carlie Lee 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Michael G. Bunitsky/Spouse 6897 Meadow Point End, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stata Resthaven Mem Gardens, Jan 6,2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Ligar M00706 106 East Church St, Frederick, Maryland 21701 etth rym Roberson 23a. Part t. Enter the disease, or complications that ceused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Sedative (Diphenhydramine) & Alcohol Overdose Hours Examine Due to (or as a consequence of): Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P 50 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 No 1 □ Yas 2 □ No Division of Vital or Attanding Physician: 80 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 X Other (Specify) 15 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 24 hours after death. Dec 31,1999 victim ingested pills & alcohl 5:30a 2 Accident 6 Could not be 3 X Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number of Rural Route Number, City or Town, Stata) 5400 Holiday Drive 4 ☐ Homicide filled in At Hotel Frederick, Maryland Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the F 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D35164 December 31, 1999 and address of person who completed cause death (Item 23a) (Type, Print) Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703 31. Date filed (Month, Day, Year) 32, Registray's Signature

**DHMH 16 Rev 6/95** 

Registrar

JAN 03 2000

Sparker



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev **Physician** John Gilbert Blades, Sr. December 23, 1999
ocation of Death 4c. County of Death 10:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 180 M 2□ F Director 217-14-4764 76 Mar. 31, 1923 Pennsylvania Usual Residence of Deceden the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits rait, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes \$ ☐ No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 701 Calvary Rd. 21028 USA 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 No 2 No if Yes, Give 1 Never Married 2 Merried "natural", or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Deputy Superintendent State Police 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health end Mental Harry Charles Blades, Sr. Mae (nmn) Weimer 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 le Sue A. Blades - wife 701 Calvary Rd., Churchville, MD 21028 If item Baltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date Burial 2 ☐ Cremetion 3 ☐ Removel from Stete **Department** Hillcrest Burial Park 12-28-99 Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part : Unter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? ributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings evaileble prior to Completed 24a. Wes en autopsy performed? completion of cause of death? SWI 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA H 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural Division 1 Tyes 2 No 2 Accident 24 hours after deal • Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 | Homicide à 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) within 2 To the I å 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature/and title of certifier 18unu 6 W 1041 30. Name and address of person who complised cause of death (Item 23a) (Type, Print) Brian T. Yeo, MD, 801 South Union Avenue, Havre de Grace, Maryland 21078

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month Pay Year) DEC 29 1999

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 9 4 2 5 8 4

Certificate of Death

				Cei	tificate of	Death			Reg. No.		
1, Decedent's Nema	(First, Middle, La	est)						2. Date of Do	eath Dey	Year	3. Time of Deeth
ician dical	CHARL	ES A	RNOLD		BUSH			Decemb	1.72	1999	1336
4a Facility Nama (#	not institution, giv	ve street and number	er)			4b. City, To	wn, or Lo	cation of Deat	h 4c. Coun	ty of Death	
Fallsto	n Gene	ral Hos	pital				Fall	ston		Har	ford
5. Social Security Nu	mber 6.	Sex 7.	Age (In yrs. la	st birthday)	If Under 1 Year		24 Hrs.	8. Dete of Bi	rth Year)	9. Birth	place (State or Foreign ntry)
205-16-5	297	M 2□F	73	Yrs.	Months Days	Hours	Min.	6/28/	1926	Pen	nsyl <b>v</b> ania
Usual Residence of I								-//			
10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
Md.	На	rford			S	tree	t				1 ☐ Yes 2 ☐ No
Md.  10e. Street and Num	ber				10f. Zip Code				10g. Citizen o	f What Cou	ntry?
85/1 Pod	laral H	ill Roa	a			2115	11		TI	C A	
854 Fed 11. Marital Status 1 Never Marrie	terar n	12. Was Decede		13.1	Wes Decedent of			cify Yes or N		S.A.	
1 ☐ Never Marrie	d 2M Marriad	Armed Force	157		f Yas, specify Cut	an, Mexica	n, Puerto	Rican, atc.)		eck, Whita,	
		If Yes, Give	FE.		1□ Yes 2M No	Specify:	-		Spec	ity a and	casian
			S.	40- D	tanta thual Oana						
(Specif	<ol><li>Decedent's E y only highest gr</li></ol>			(Give	tent's Usuel Occu kind of work done	durina mos	st of working	ing	16b. Kind of		dustry
(Special	dary (0-12)	College (1-4d			DO NOT use retire		0		Harf		
8	ED 1 000 000 1 1 1 1	-	Щ	eavy	Equipm		_				ighways
17. Father's Name (F	irst, Middle, Last	"				18. Mothe	er's Neme	(First, Middle	, Maiden Sumi	ame)	
Davi	d El	lsworth	. В	ush		E	lla	Ma	ay	Smit]	h
19e. Informant's Nar	ne/Relationship	(Type, Print)		19b. Meilir	ng Address (Stree	t and Numb	er or Aura	I Route Numb	er, City or Tow	n, Stata, Zi	o Code)
Beverly	Bush	/Wife	10	S	ame as	#10	a.b.	c,e,f			
20a. Method of Dispo			000		sition (Name of natory or other pla		1	2/22	20c. Location	- City or To	own, Stata
	Cremetion 3 D	Removal from Sta	10	100					Tama	++~==	illa Ma
21. Signature of Fun			JWII	77	Watter			1999	Jarre	UUSV.	ille, Md.
777	2//	TT 62	11	/ "	E.G. K	urtz	& 5	son Fu	neral	Home	e. P.A.
E.G. Kurtz & Son Funeral Home, P.A.  Jarrettsville, Maryland  23a. Partl. Enter the disease, or complications that caused the softh. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate											
23a. Part1. Enter the shock, or heart	disease, or com	plications that cause on each	sed the death.	Do not ent	ar the mode of dy	ing, such es	cardiac o	r respiratory	errest,		Approximate Interval Between
	Onset end Death										Onset end Death
Immediate Cause (F	inal	Ac	UTF	RET	SPIRATORY FAILURE					- !	2 DAYS
resulting in death)		a			/he seese!					1	~DIII G
1 3 48		CHO	ONIC	as a conseq	STRUCI	TIVE	@1/ /	WANIAR	V Dis	EASE	
		b. CIPE				100	107	2011111	1 713	01/36	
Sequentially list conditions, leading to immoduse. Enter Underlicause (Disease or immodule)	ditions, nediata		Dua to (or a	as a conseq	uence or):						
Cause (Disease or in that initieted events	ying ijury	C								1	
resulting in death) La	st		Dua to (or e	s a conseq	uence of):						
		d.								1	
Part II. Other signific	ant conditions	contributing to death	but not result	ting in the u	nderlying cause gi	iven in Part	l.	23b. Did	tobacco use o	ontribute t	to the cause of death?
								1 🕃	fes 2□ No	3 Pro	bably 4 Unknown
								24a. Was	an autopsy		/ere autopsy findings
								pert	ormed?	CC	vailable prior to empletion of cause death?
								10	Yes 2 No	1	☐ Yes 2☐ No
25. Wes case referre examiner?	d to medical	88			1 -		e of Death	(Check only	one)		
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27. Manner of Death	€ □ Decetion	28a. Data of f	njury Day Year) 2	8b. Tima of fnjury	28c. tnju	ry at ork?	1	28d. Describe	how injury occ	urred	
1/Q Natural 2 Accident	5 Pending investigation		,,	qui y		Yes 2□	No				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	286. Place of	fnjury - At hor	ne, ferm, str	eet, fectory, office	Y		28f. Location	Street and Nur	mber or Aur	al Route Number,
4 [] Nomicide		building,	etc. (Specity)					City of To	wn, State)		
29a. Certifier	(70) Cartifying Pt	ysician: To the be	st of my knowl	edne deeth	occurred at the ti	ima data en	nd place a	and due to the	cause(s) and i	manner as r	hoteta
	Medical Exam	niner: On the basis and manner	of axaminetic	on and/or inv	estigation, in my	opinion, dea	ath occurre	ed at the time,	data and place	e, and dua t	to the cause(s)
29b. Signature and ti	lle of certifier	and manifes	-verou.		29c Licen	se number		1	29d. Dete sign	and /Month	Day Year)
Loo. Organization and to		2 1	/	40.00	7.7.		91				
An	suu/	buols.	nues	ny	000	80	16		DECER	グラド人	19, 1999
30. Name and address	s of person who	completed cause o	f death (ttem 2	23a) (Type,	Print)	. /	. ,				01 111
ANDRE	NO NO	WAKO	voki	MAD	105	V. MA	MN.	ST. P.	TELITY!	1,1012	21014
31. Data filed (Month	Day, Year)		strar's Signetu	ra /	1						
r Data med (Month	C 2 1 19	199	was	1.	Sport	2					
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DHMH 16 Rev 6/95

Charles Arnold Bush

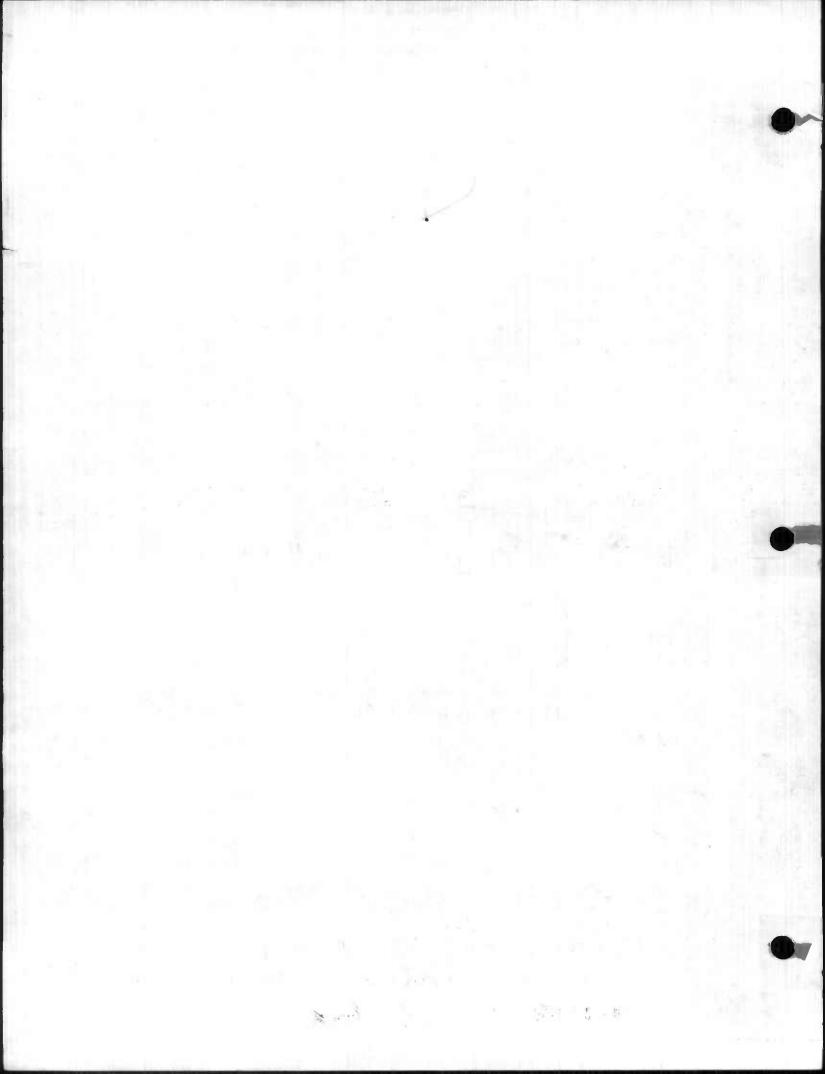
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Jacob Crawford Briney 1999 Dec. 19 1115 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F Yrs. Director 218-14-4201 93 09/28/1906 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or farms 29—any injury or other treumatic event. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Old Level Road USA 21078 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Farmer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emily Crawford Howard L. Briney 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Rosalie B. Smith- Daughter 514 Jo Ann Drive, Odenton, MD 21113 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemetery 12/22/99 Havre de Grace, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Mitchell-Smith Funeral Home, P.A. 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. MD 21078 Approximete Intervel Between Onset and Deeth **Physician** Ymphoma - Non Hodgkin's Immediete Cause (Finel disease or condition resulting in death) /Medical ROW Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Congestive fleare farlers 1 Yes 2 No 3 Probably 4 Unknown Brined, Crawford Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Director: After this cartific I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Neturel 5 Pending investigation death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/20/09 1 When au D 32609 MD 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MD21078 MITHAMI MD. TOB Revolution St + fars & De Grove

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) DEC 2 1 1999

32. Registrar's Signature Gamera



Registrar

State

Margarita Korell M.D.

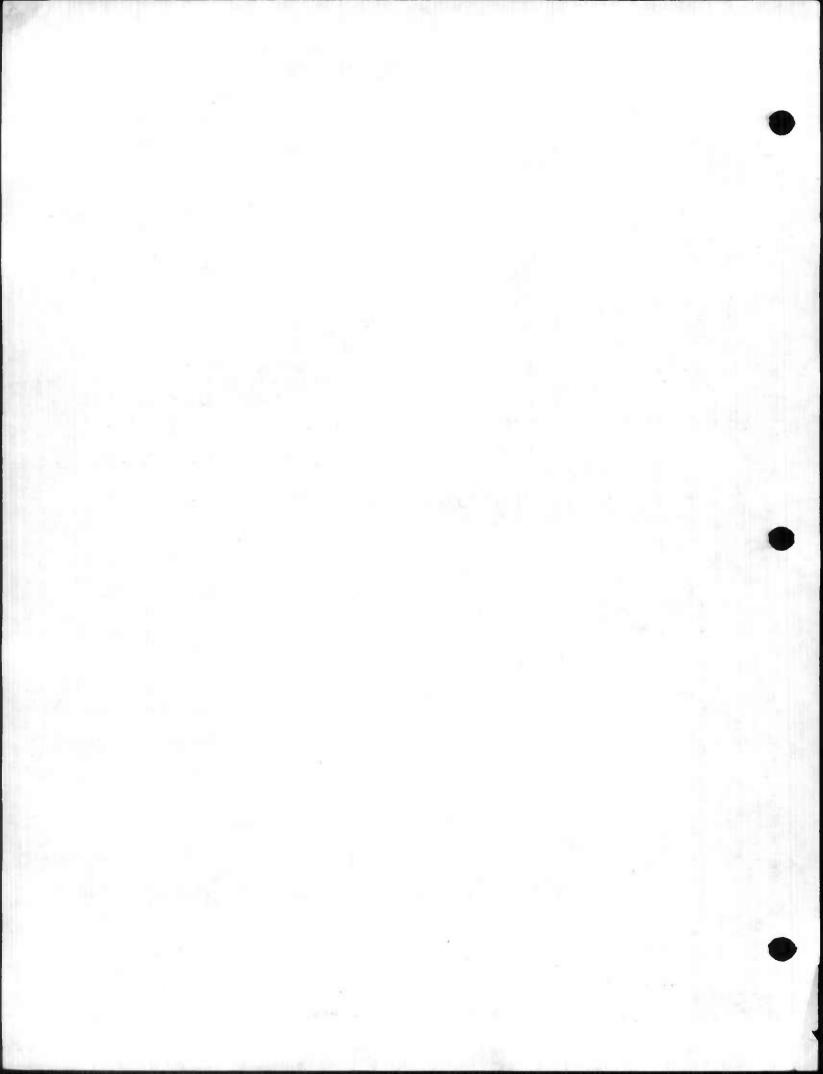
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31. Date filed (Month, Day, Year)

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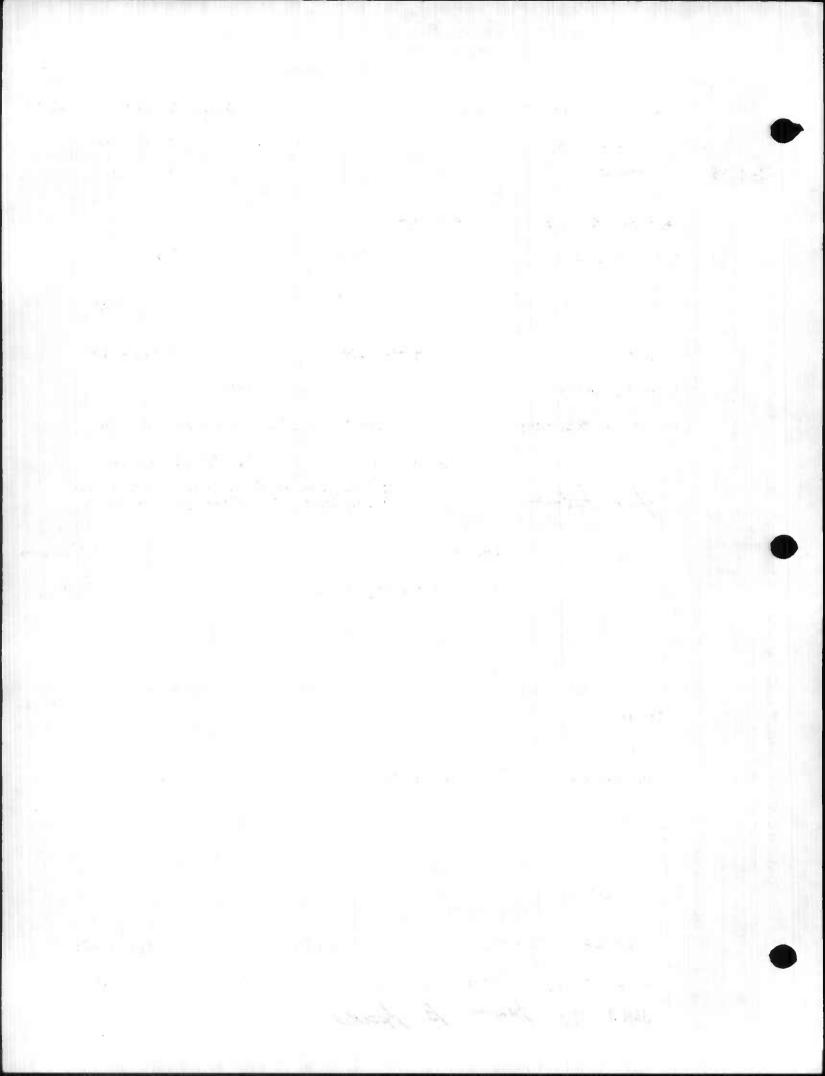
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



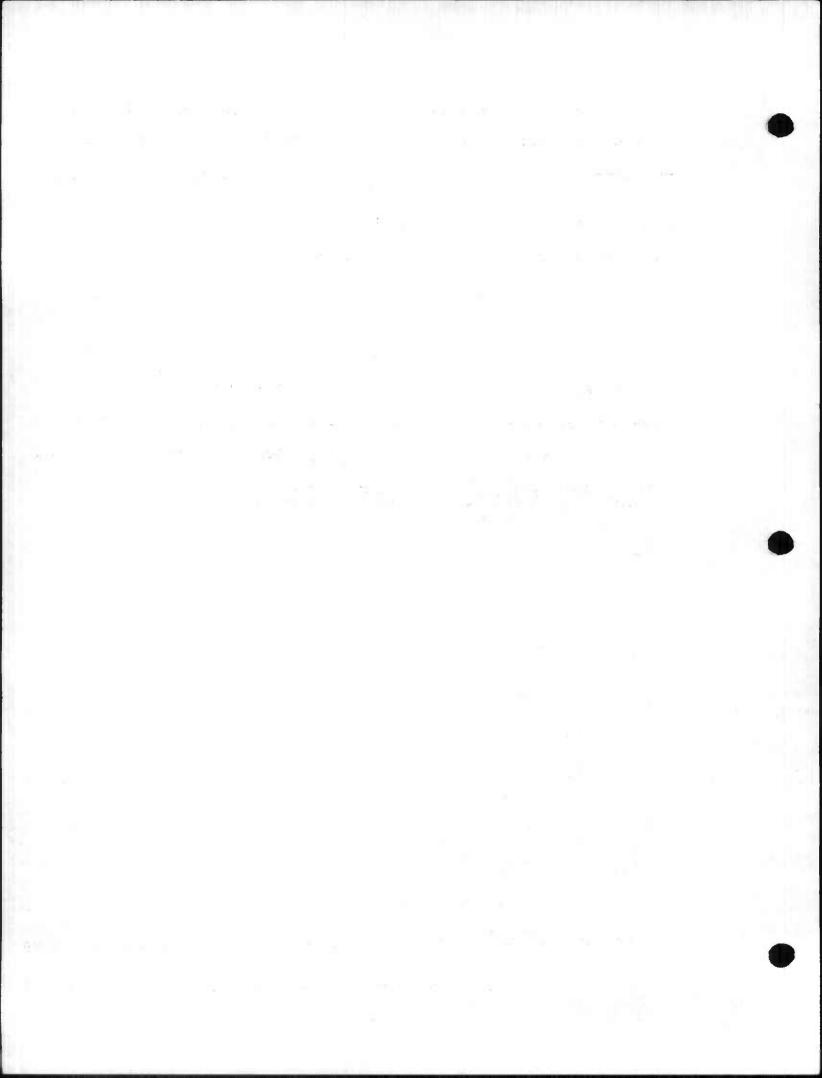
# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otato of IV	iai yiaiia i		tificate of	Death		leg. No.		2587	
п	Division		1. Decedent's Neme (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death	
ш	Physicia /Medica		Paul Wilson	n Bottom1	ey	_			Dec.	31 199	99	10:00 am	
	Examine		4a Facility Neme (If not institution	give street end number	7)			4b. City, Town, or L	Location of Deeth 4c. County of Death				
			402 Lime Landing Rd.					Millingto	on	Queen			
	Funeral Director		5. Social Security Number 221-07-9028	6. Sex 7. A ▼© M 2□ F	ge (In yrs. lest b	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Dete of Birtl (Month, De) April 3	Year) , 1913	9. Birth Cou Mill	place (State or Foreign ntry) ington	
	ryland		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits	
	the Marylar 28a-f show	Director	Maryland Queen Annes Millington									1 ☐ Yes 2180 No	
	th th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V	/hat Cou	ntry?	
	23a or	e l	402 Lime Landir	ig Rd			21651			USA			
020	~ 0 =	by Funeral	11. Meritel Status  1 Never Married 2 Merri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ed 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Dates:	?   No		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp. an, Mexicen, Puerto Specify:	ecify Yes or No- Ricen, etc.)	14. Race Blac Specify	k, White		
0-0	2 ho	D E	15. Decedent	s Educetion	16	a. Deced	ent's Usual Occup	petion		16b. Kind of Bu			
21215-0020	s i and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, tra Mag an Ear	Completed by	(Specify only highes Elementery/Secondary (0-12) 5Vrs	College (1-4or		life. C	Worker	during most of work d)	ang	Constr	ncti	on	
	Hyg Hyg off,		17. Father's Neme (First, Middle, I	ast)			WOLITEL	18. Mother's Nam	e (First, Middle,			0.2	
Maryland	2 should be filed with and Mental Hygiene. 8 marked other than sumatic event, the	To Be	Harry Bottomley	r				Agnes P	inion				
ary	should ind Meni		19a. Informant's Name/Relationsh		19	b. Mailin	g Address (Street		The state of the s	r, City or Town,	City or Town, Stete, Zip Code)		
	and 2 : eaith ar n 27 Is		Esther Ann Bott	omlev	4	102 T	ime Land	ding Rd.	Millingt	on. Md	216	51	
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20e. Method of Disposition		20b. Piace	of Dispos	sition (Neme of netory or other pla		Date	20c. Location -		P	
E	Peges net of I nt: If ite iry or o		1 ☐ Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		9		Cemetery		01/4/00	Milling	ton	МА	
atti	permit. Pe Departmen important: any injury pnce.	ŀ	21. Signature of Funeral Service I		LIBRO	22	Name and Addre	ess of Fecility					
m	Depa impo any l		Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, Md 21651  23a. P. Int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, interval Between and Do Onset and Do Do Do Do Do Do Do Do Do Do Do Do Do										
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4	Physician	П										Onset and Death	
٧	/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)  e.								24rs		
в		_	resulting in deality		Due to (or as	n.					1	2.000	
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	E 0 6	_	resulting in death) Last		Due to (or as a	CONSEQU	adrice ory.						
Box	eath certific ettending p for use as	Physician/M		d							1		
	the elf	200	Part II. Other significant condition	as contributing to death	but not resulting	in the un	nderlying ceuse gi	ven in Part I.	23b. Did 1	obacco use co	ntributa	to the cause of death?	
, P.O.	law requires that the death cert as been signed by the ettendin 2 should be detached for use	by Phy	HTN						10	res 2□No	3 Pro	obably 4 Unknown	
of Vital Records,	n sign	D	TIM						24a. Was	an autopsy	24b. V	Vere autopsy findings valleble prior to	
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a	ysician: The last certificate hadirector, page		25. Wes cese referred to medical		C 100 100	,,,,,,,		26. Place of Dea				2.00 22.00	
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0	는 토교		27. Manner of Death	28a. Dete of Ini	iury 28b	. Time of	28c. Inju			now Injury occur			
ion	oding ith. : Afte		Natural 5 Pending		ey Year)	Injury		Yes 2 No					
Division	Atter or des by th	20	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determi	ned 256. Place of Ir	njury - At home,	farm, stre	eet, factory, office		28f. Location (S City or Tox	Street end Numb	er or Ru	rel Route Number,	
Ö	of in Direction	Certification:	4 🗆 Homicide	building, e	etc. (Specify)				City of Toe	ni, Siele/			
		edical	29a. Certifler Certifying (Check only one)	Physician: To the best examiner: On the basis and manner s	of examination a	ga, death and/or inv	occurred at the ti restigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	ceuse(s) end ma date and piece,	nnar as	stated. to the ceuse(s)	
	outh ompl	E E	29b. Signature and title of certifier	= 120		7	29c. Licen	se number		29d. Date signe	d (Month	, Dey, Year)	
	- 5 - 0		) the	nuo			57	1890		11	1/7	000	
		-	30. Name end address of person v	who completed seuse of	death (Item 224	) (Type I					1		
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	State		31. Dete filed (Month, Dey, Yeer)	32. Regis	trer's Signature		,						
	Registra	r	JAN 3 2006	Line	Ø.	de	souls						



8	amend ite	m 5	State of Maryland / E per informant G788 10/30/00 yf	Certificate of			eg. No.	42588			
	Phys <u>ic</u> /Medi		1. Decedent's Name (First, Middle, Last)  Angela Brzostowski			2. Date of Deer Month Decemb					
2	Exami		4e. Facility Neme (If not institution, give street and number)  Copper Ridge Nursing Home		4b. City, Town, or Lo Sykesvill	cation of Death	Death 11 Co.				
	Funerai Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest bir.		If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day) April 26,	Year)	D. Birthplace (State or Foreign Country)  New Jersey			
	and w		Usual Residence of Decadent           10e. Stete         10b. County         10c. City, Town	n or Location		I PLANT LOY	1525	-			
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	or 28a	Oirec	10e. Street end Number	10f. Zip Code		1	0g. Citizen of Wh	at Country?			
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)20	permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Maritel Stetus  1 □ Never Merried 2 □ Married  1 □ Never Merried 2 □ Married  1 □ Yes ② □ Noread  1 □ Yes Give Year or Dates:	13. Wes Decedent of H If Yes, specify Cub  1 ☐ Yes 2 ▼ No	dispenic Origin? (Spen, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.			
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Maryland	s mar	-	19e. Informant's Name/Reietionship (Type, Print)	Mailing Address (Street	and Number or Run	al Route Number	, City or Town, St	ete, Zip Code)			
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altimore,	Peges I tment of F tant: If ite		Buriel 2 Cremetion 3 Removal from State Donetion 5 Other (Specify)	Disposition (Name of y, cremetory or other ple- Cross Cemete 22. Name and Addre	ery Jan. 4			ty or Town, State lington, N.J.			
Bal	Depar Impor		21. Signature of Funeral Service Licensee M-00849 Part T. Lock samp for	leveland,	ОН. 441	13					
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			76	D328	82		Decembe	er 30, 1999			
		1	30. Name and eddress of person who completed cause of deeth (item 23a) ( Robert L. Moss, MD, 114 Bus		ter Driv	e Poi	eterat-	NA 2113			
	Sta	te	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture	2		e, kel	stel2[(	JWII, MQ. 2113			
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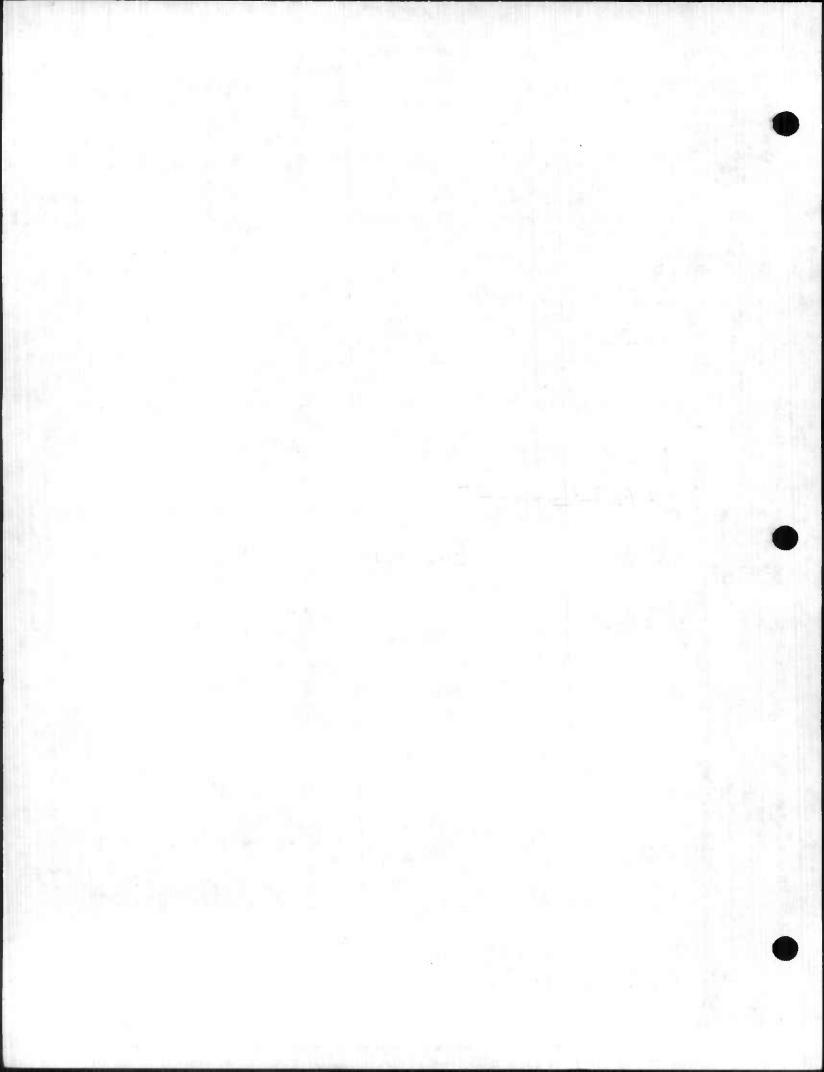


99-Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene LEWIS D Certificate of Death BURKHOLDER 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Dey **Physician** David Burkholder Lewis DECEMBER 30, 1999 20:19 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hagerstown WASHINGTON COUNTY HOSPITAL WASHINGTON If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) June 21 1956 9. Birthplace (Stete or Foreign Mary Land 8. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 213-72-7870 43 Yrs. Director Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Washington Clear Spring Nerne 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? the Medical Examiner must be 14128 Spickler Rd. 21722 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 8 Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 10 Farmer Agriculture 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) nd Mental mericad or Jacob H. Burkholder Emma E. Martin 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) systimant of Health as important: if them 27 is n any injury or other to 14128 Spickler Rd. Clear Spring, Md. 21722 Charlotte Burkholder/Wife Baltimore, 20b. Place of Disposition (Name of Lemeter), cremetery, cremetery, cremetery or other place)
Miller's Mennonite Church 1/4/2000 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlei 2 ☐ Cremetion 3 ☐ Removei from Stete Leitersburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 21. Signeture of Funeral Service Licenses 17225 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. ntervei Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical -LECTROCUTION Examiner Due to (or es e consequence ot) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or es a consequence of): Box 68760. attending physician Due to (or as e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Py Division of Vital Records, 24b. Were autopsy findings evaileble prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? Yes 2 No Yes Yes 2 No I or Attanding Physician; after death. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2X ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural working on ELECTRICAL APPLIANCE 12 30 99 71 30 PM 10
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number of Rural Route Number City or Town, Stete) 14128 Spick(ES &C 4 Homicide Spickles Rd. CLEARSPRING, MD HOME To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner as steled.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier OCME DECEMBER 31, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) JACK MID 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Montt) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Janet Louise Christophel 0015 December 30 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Washington Hagerstown Hours Min. 8. Date of Birth Month, Day, Year)
Jan. 20, 1945 5. Social Security Number 6. Sex If Under 1 Yeer 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months | Deys 1□M 20 F Penna. 168-36-9239 54 Yrs Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Madical Examinar must be notified at PA. Franklin Greencastle 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13587 Worleytown Rd. 17225 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or there eyen, the Medical Example. Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian 11 Church 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Paul Dean Carbaugh Ruth Virginia Bingaman 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayde L. Christophel Sr./ 13587 Worleytown Rd. Greencastle, Pa. 17225 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Macedonia Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/2/2000 Greencastle, Pa. 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 21. Signature of Funeral Service Licensee 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 week neumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner mphong physician and the buriel-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): of Vital Records, P.O. Box 68760, that initiated eventa resulting in death) Last Due to (or as a consequence of): USB 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 ☐ Yes 1 Yes Physicien: 25. Was case referred to medical examiner? Certification: To Be 28. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death

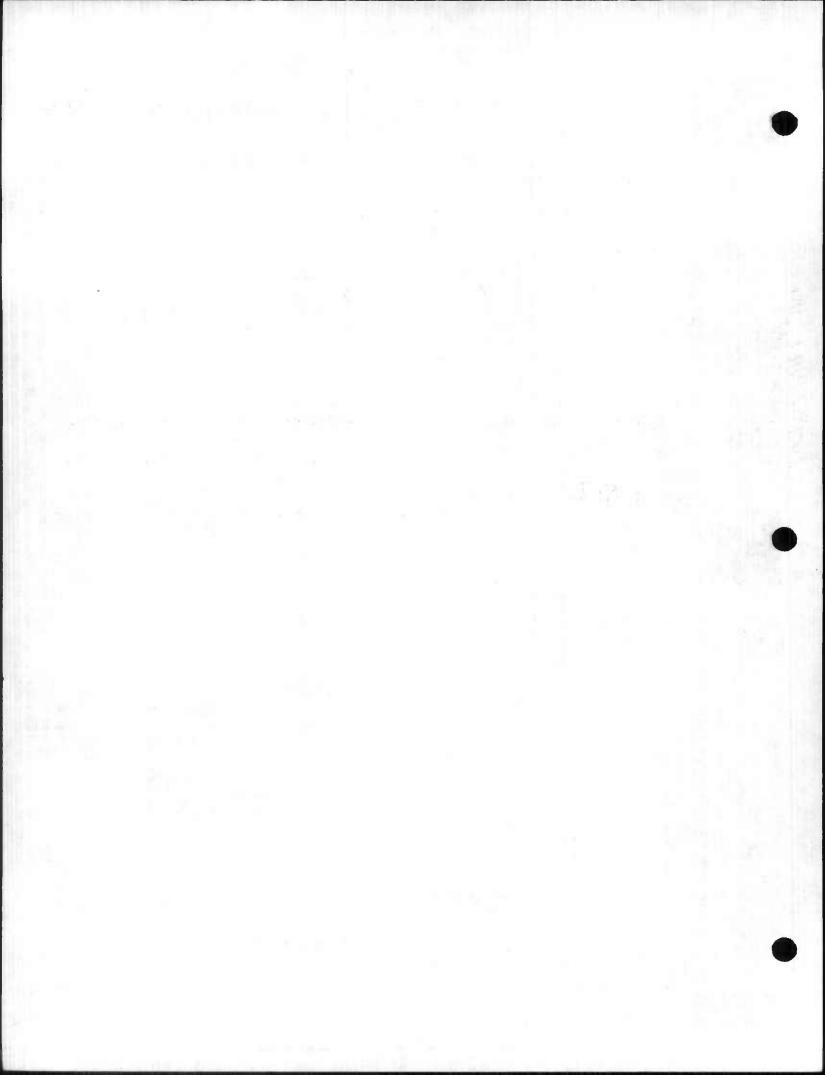
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2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation death. 1 Yes 2 No 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier completely (Check only one) within 2. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 150813 12/31/19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Omalley apper Rd Suit 127 Hagerstown, MO 21742 Milica 11110 31. Date filed (Month, Day, Year) JAN 03 2000 32. Registrar's Signature State

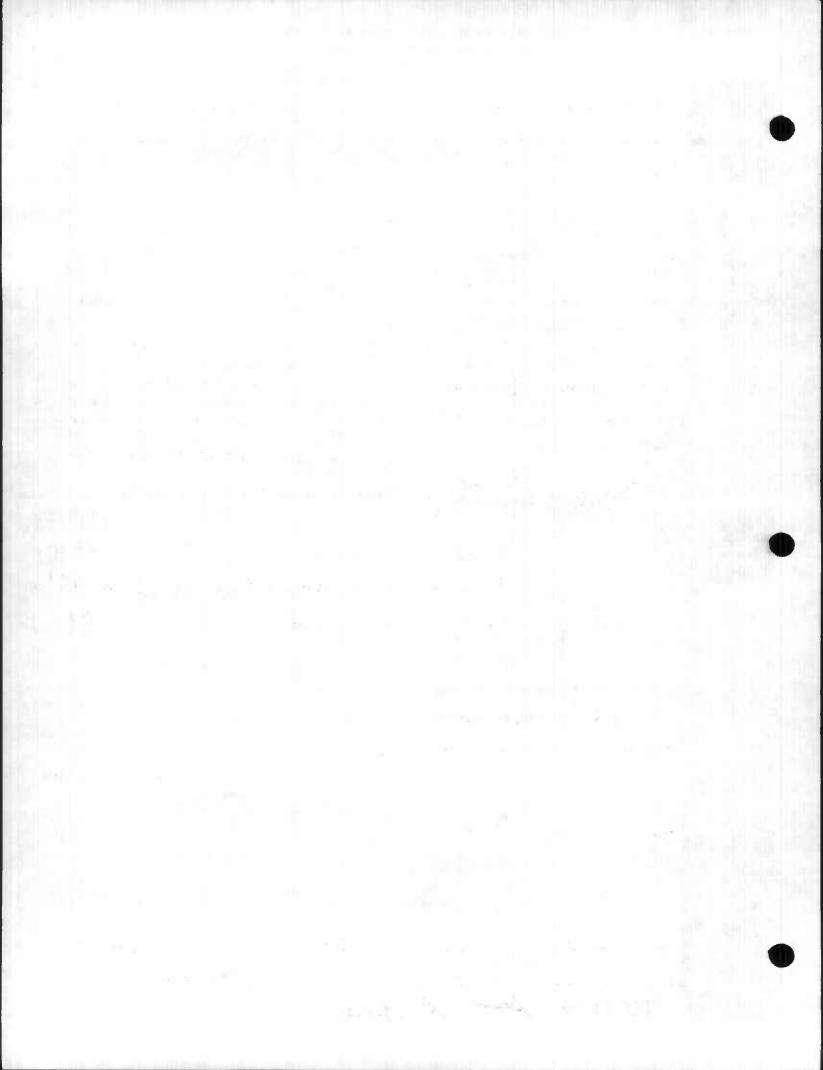
**DHMH 16 Rev 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene 99 1, 2591

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1   yes 2   No 3   Probably 4   Unknown    Americal exempts   Americal	Bo	atten 1 for u	clar				and Death	not Dida		-0-16-10-0	a the same of death?
24a. Was an autopsy performed?  24b. Wars autopsy performed?  1   Yes   2No    1   Yes   2No    25. Was case referred to medical axaminar?  1   Yes   2No    25. Was case referred to medical axaminar?  1   Yes   2No    26. Pieca of Daeth (Chack only ona)  27. Mannar of Deeth   Nursing Home   5   Residence   6   Othar (Specify)    28c. Deta of Injury   28c. Injury at   North, Dey Year)  28c. Piaca of Injury - At home, farm, streat, factory, offica    28c. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number or Rural Route Number, City or Town, Stete)  28d. Location (Street and Number	o.	the d	ıysi		4	and the state of t	ven in Pert I.		V		
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25. Wes case referred to medical axaminar?	ecord	aw ls b	pieted	Americalerer's coron	ory art.	disease				ev	reliable prior to empletion of cause
25. Wes case referred to medical axaminar?	2	0 - 0	PO.		,			1 □ Y€	s 2 No	10	☐ Yes 20 No
State   Stat	/ita	slan: artific actor,		avaminar?				th (Chack only on	a)		
State   Stat	7	5 00	မ	1 ☐ Yes 2 No Hospital:		Apetient 3 DOA	4 LI Nursing H				<b>y</b> )
State  MD  D51735  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  13/26/9		ing P	on:	Natural 5 Panding (Mont	of Injury th, Dey Year) 28b.			28d. Describe ho	w Injury occur	red	
State  MD  D51735  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  13/26/9	ivisio	er death rector: A by the f	tificat	3 Suicide 6 Could not be determined 28e. Placa	of Injury - At home, fa		Yes 2 No			per or Rura	al Route Number,
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State  MD  D51735  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  13/26/9		in 24 he Fu platal				ovor investigation, in my o	opinion, daeth occu	red et the tima, d	ata end placa,	end due to	uie ceusa(s)
State  MD  D51735  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  12/26/99  13/26/20  State  31. Data filed (Month, Day, Yaar)  13/2. Ragistrer's Signeture  13/2. Ragistrer's Signeture		with.		29b. Signature and tiple of certifier				2	9d. Date signe	d (Month,	Day, Year)
State 31. Data filed (Month, Day, Yaar) 32. Ragistrer's Signeture				1	WD	D5	1735		12	126	19
State 31. Data filed (Month, Day, Yaar) 32. Ragistrer's Signeture							11 Rd.	Cheste	John,	Md	21620
Registrar DLO N 9 1999						los v.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** 27, 1999 Ruth December Mae 8:45 P.M. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 601 Cornell Street Apt. 100 Aberdeen Harford If Under 1 Year 8. Date of Birth (Month, Dey, Year Jan. 28, 1 If Under 24 Hrs Hours Min. 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1 M XXF 1922 Virginia Director 215-34-6054 permit. Pegas 1 and 2 should be filed within 72 hours aftar death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 23s-f show any Injury or other traumatic event, in Medical Examiner must be not any 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 N Yes 2 No MD Harford Aberdeen Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 601 Cornell Street Apt. 100 21001 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Biack, Whita, atc. ☐ Yas 2 I Yes, Give 1 Navar Marriad 2 Married 2 No 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker In home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Everrett Mines UNK Mae 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Albert K. Cooper, Jr. (Son) 723 Sequoia Drive, Edgewood, Maryland 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cramation 3 Removel from State Bel Air Memorial Gardens 12/30/99 Bel Air, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Fuperal Service Licensee 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Betwaen Onsat end Death **Physician** /Medical immedieta Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Physician/Medical Examiner nding physician and use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or as e consequence of) Records, P.O. Box 68760 Due to (or es e consequenca of) for signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to complation of cause of death? 24a. Wes en eutopsy performed? Completed page 2 2000 1 Yes 1 ☐ Yes 2 ☐ No cartificata Division of Vital Attending Physician: director, 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this tha funaral 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hospital or Attand 24 hours aftar death Funeral Director: A 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical complately (Check only one)

State Registrar

1308 31. Date filed (Month, Day, Year) 99

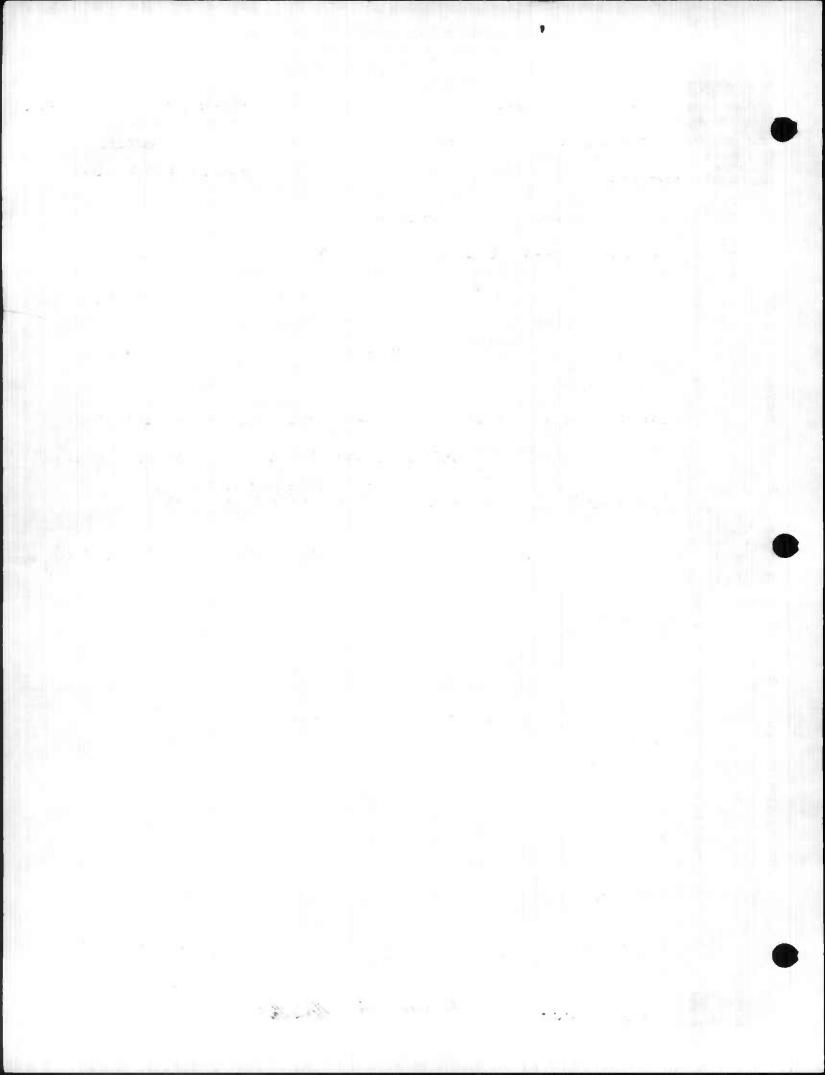
30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture end title of cartifier

2 Course Signature

29d. Date signed (Month, Day, Year)

B. Sparks



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death Year Month SLIZABETH MARY CIARPELLA

7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

DEC

Jan. 28,

BELAIN MOZIOIL

4b. City, Town, or Location of Death

FALLSTON

30

1999

HARFOND

4c. County of Death

10g. Citizen of Whal Country?

USA

3. Tima of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Ireland

White

U/K

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

Own Home

11=47 AM

Physician
/Medical
Examiner

4a Facility Name (If not institution, give street and number)

10b. County

5. Social Security Number

Usual Residence of Decedent

216-24-1490

10e, Street and Number

Maryland

ER FALLSTON GENERAL HOSPITAL

76

10c. City, Town or Location

Bel Air

10f. Zip Code

10 M 20 F

6. Sex

Harford

**Funeral** Director r than "natural", or hame 23a or 28a-f ahow the Medical Exempler must be notified at "natural", or hams 23a or

pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: if them 27 Is marked other than "natural", or han any injury or other treumatic avent, the Hedgel Emmine once.

8

Baitimore, Maryland 21215-0020

Box 68760;

Records, P.O.

Division of Vital

Physician /Medical Examine

Physician/Medical Examiner é Completed Be

attending physicien end for use as the burlei-transit that the death certificate be assecuted signed by the a The law requires page 2 s Certification: To this Aftert or Attending death. Director: / hours after in 24 hour. the Funeral Direction Hospital edical To the Hosp within 24 ho To the Fune completely fi

Director 1018 Vale Road 21014 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2000 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 TNo Specify: þ **3**€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) U/K U/K Carr U/K U/K 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Ciarpella - Daughter 1018 Vale Road, Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gardens 1/3/2000 Fallston, MD 22. Name and Address of Facility
McComas Funeral Home, P.A. e of Funeral Service License ter the deather or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland Immediate Cause (Final Cardio vacular Misus · Arterioscherche disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Xes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DOME OCME 17-30-1999

**DHMH 16 Rev 6/95** 

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

218

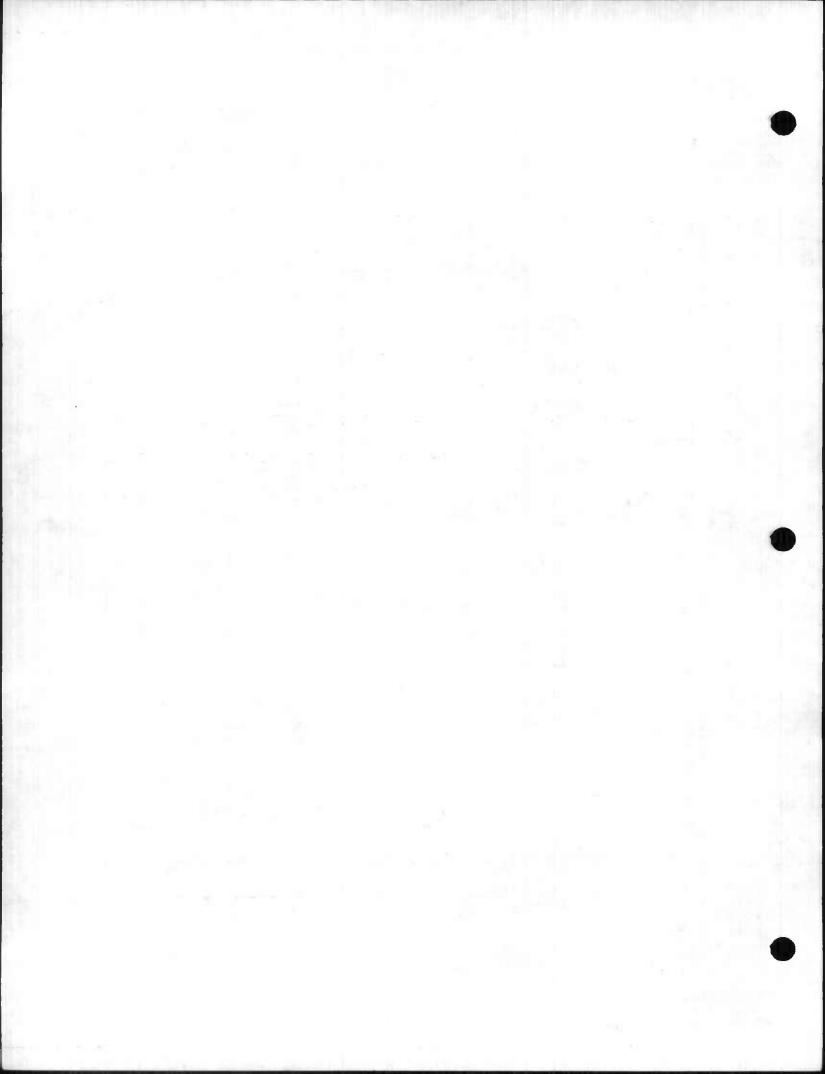
32. Registrar's Signature

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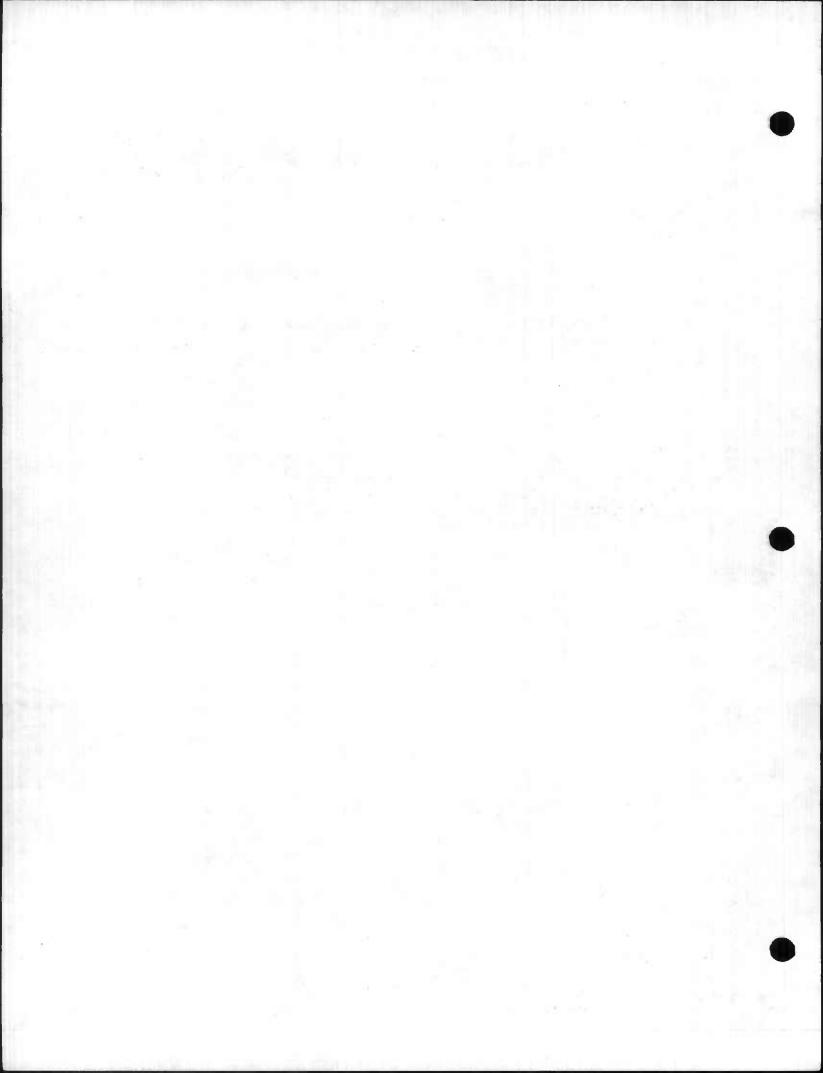
31. Date filed (Month, Day, Year)



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

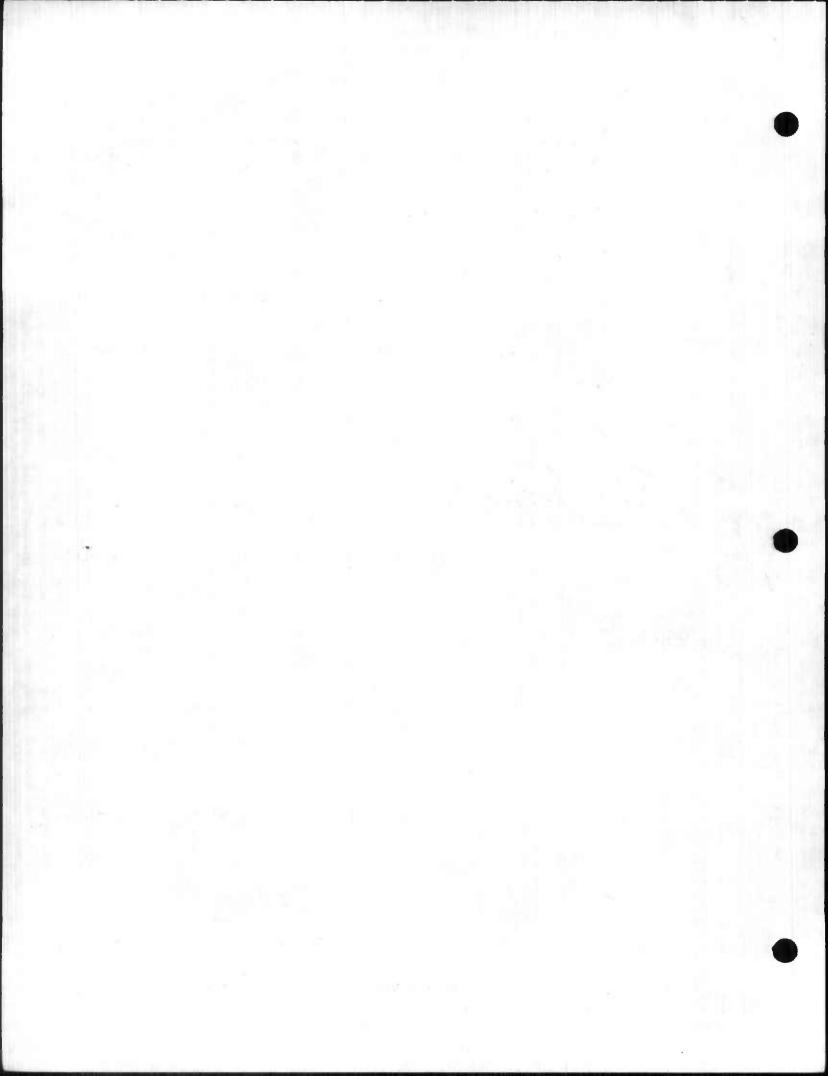
			Certificate of	f Death	Reg. No.	99 42594
Physician /Medical	<ol> <li>Decedent's Name (First, Middle, Last John Lynwood Cri</li> </ol>			2	Date of Death Month Day  Combe 2	Year 02.00
Examiner	4e Facility Neme (If not institution, give Fallston General			4b. City, Town, or Local Fallston	tion of Death 4c. 0	County of Death Harford
uneral irector	5. Social Security Number 225–32–8691 6. S	7. Age (In yrs. Ii	ast birthday) If Under 1 Yea Months Day	s Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Virginia
-	Usual Residence of Decedent  10a. Stete 10b. County	10c. City	, Town or Location			10d. Inside City Limits
0	Maryland Harford		el Air			1 ☐ Yes 2 ☑ No
by Funeral Director	10e. Street and Number 1208 St. Franci		10f. Zip Code 210.			en of What Country? JSA
by Funeral	11. Marital Status  1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 Styes 2 □ No It Yes, Give Yeer or Detes: Kore	1 ☐ Yes 2 🖫 N	Hispanic Origin? (Specifiban, Mexican, Puerto Rico Specify:		4. Race - American Indian, Bleck, White, etc. Specify: White
Completed	15. Decedant's Ed (Specify only highest gra Elementery/Secondery (0-12)	ucation	16a. Decedent's Usual Occ	e during most of working red)		d of Businass/Industry fic Engineering
	17. Fethar's Nama (First, Middle, Last)	2	TICIA DAPCIV		First, Middle, Maiden S	
To Be	Thomas Spotswood	Critzer			Drumheller	
F	19e. Intorment's Neme/Ralationship (7	ype, Print)	19b. Melling Address (Stre			
	Peggie Watson Cri	tzer/Wife	1208 St. Fra	ncis Road, I	Bel Air, M	D 21014
	20e. Method of Disposition  1 Description  1 Other (Specify	Domougl from State	ece of Disposition (Name of ametary, crematory or other partial	lece)		ation - City or Town, State  Air, Maryland
MINE	21. Signature of Euneral Service Licen		22. Name and Add McComas	ress of Fecility Funeral Home	e, P.A.	Air, MD 21014
Examiner		a. Chronic C  Dua to (or	as a consequence of):	resmonary	Disegre	Syears
ledicai	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last	C	es e consequence of): as e consequence of):			
Physician/N	Part II. Other significant conditions or		iting in the underlying cause of	riven in Part I.	23b. Did tobacco u	use contribute to the cause of death
by Phys	Gastrointestinal	bleeding			10 Yes 20	No 3 Probably 4 Unknow
Completed		0			24a. Was an autops performed?	24b. Wara autopsy findings available prior to completion of cause of death?
O.				4	1 □ Yas 2 €	No 1 □ Yas 2 □ No
Be	25. Wes casa refarred to medical examiner?			26. Placa of Death (C	Check only one)	
2	1 ☐ Yes 2 X No	Hospitel: 1 Denpatient 2 E	ER/Outpatient 3□ DOA C	ther: 4 Nursing Home	5 ☐ Residence 6	□Other (Specify)
Certification:	27. Manner of Deeth  1 Netural 5 Panding 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	M 1	ork? ☐ Yes 2 ☐ No	d. Describe how injury	
	4 Homicide determined	building, etc. (Specify,			City or Town, Stete)	
edical	29e. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best of my know iner: On the basis of examineti end manner steted.	rledge, death occurred at the on and/or investigation, in my	tima, data and place, and opinion, deeth occurred	due to tha cause(s) a at the time, data end p	and manner as stated. place, and dua to the cause(s)
+/ Medical Cert	29b. Signature and title of certifier	nyde mp		36 42		e signed (Month, Day, Year)  My Sev 26, 1999
8	30. Name and addrass of person who of the state of the st	ompleted causa of death (Item  754  32. Registrer's Eignet	lickory Ave	BelAr	MD 21	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 42595

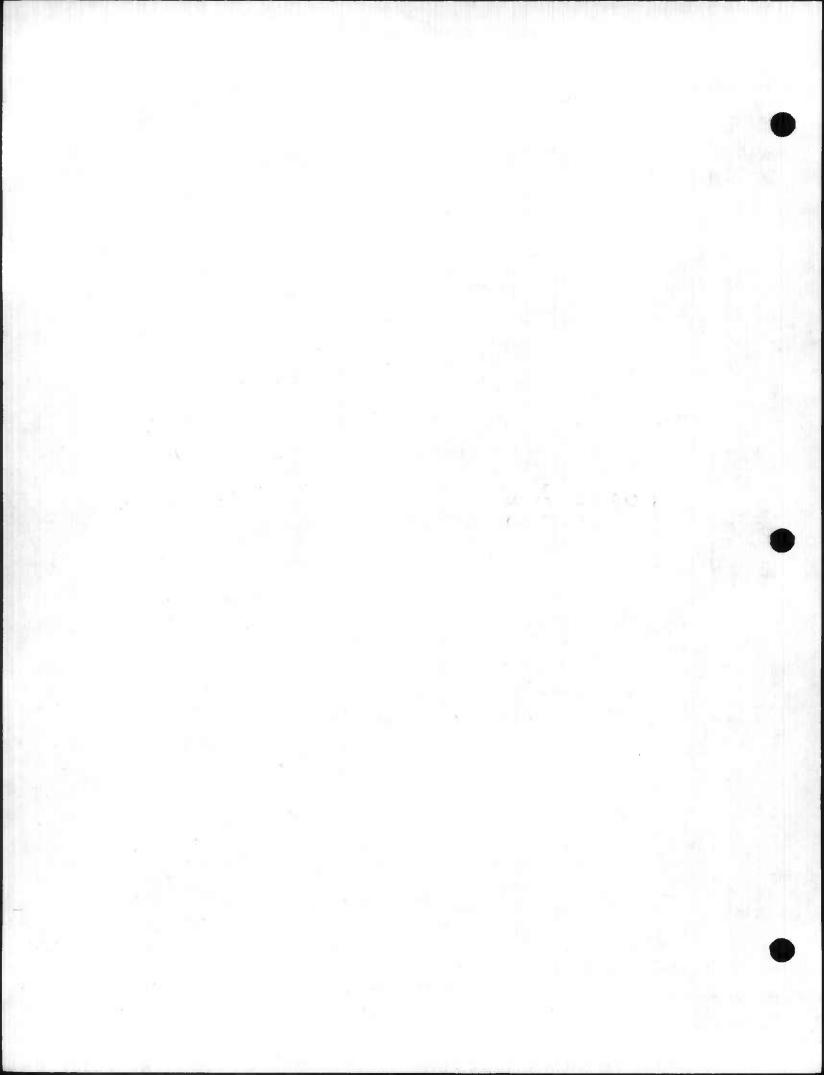
					Certifica	ate of	Death		R	eg. No.	0 0	7	000
	Physician	Decedent's Name (First, Middle, L BLANCA RUBI.							2. Date of Dea Month DEC. 3	th Day 0, 199	Year 9		a of Death
	/Mediii' Examiner	4a Facility Name (If not institution, gi	ve street and number	)			4b. City, To	wn, or Loc	cation of Death	1	ty of Death		
		1405 Grouse Cou	rt					leric	k	Fred	erick		
	Funeral Director		Sex 7. A	ge (In yrs. last b	Yrs. If Un Monti	der 1 Yea ns Days		24 Hrs. Min.	8. Date of Birth (Month, Pay 3-31-19	Year)	9. Birthp E1 Sa	lace (State)	dor
	a-f show tified.st	10a. State 10b. County	ick	10c. City, Tov Frede	wn or Location rick						1		e City Limits
	death with the Marylai kmat be notified at meral Director		rt		10f.	Zip Code 2170	3		1	Og. Citizen of		ntry?	
020	or after Examina by Fu	3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give 4 Year or Dates	r kno	If Yes, s	pecify Cu	ban, Mexicar	n, Puerto F	city Yes or No- lican, etc.)	Bi	nce - Americ ack, White, WHISP	etc.	n,
50	72 ho	15. Decedent's E (Specify only highest gr		166	a. Decedent's U	suel Occu	pation during mos	t of workin	10	16b. Kind of	Business/Inc	dustry	
2121	within then then mpl	Elementary/Secondary (0-12)	College (1-4or 4 years	5+)	(Give kind of life. DO NOT Homemak		ed)			Но	memak	er	
Maryland 21215-0020	Sabe a	17. Father's Name (First, Middle, Las	1)						(First, Middle, ria Jai		me)		
Mary	aith and Men 27 is marks or traumatic	19a. tnformant's Name/Relationship Wilfredo Garcia			b. Mailing Addr 209 Bis				<i>Route Numbe</i> e Frede	-			
Baltimore	Pages 1 in nent of He mit: If Item ary or other	20a. Method of Disposition  1 Burial 2 Commetion 3 [ 4 Donation 5 Other (Special			of Disposition (I		tory	1,	Dete /2/2000	20c. Location Smith			
9	Physician /Medical Examiner	23a. Part L Enter the disease or conshock, of heart feature. List only Immediate Cause (Finet disease or condition resulting in death)		ASTA	not enter the n	LE	ring, such es	cardiec or		est,		2170 Approx Intervel Onset	mate Between and Daeth
60,	certificate be assocuted be because and associated and associated	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events	b	Due to (or as a	consequence (	of):					1		
Box 68760,	nding physicia use as the bur nVMedical	resulting in death) Last	d	Due to (or as a	consequence of	of):							
ă	# # # B B	Part II. Other significant conditions	contributing to death	hut not resulting	in the underlyin	o canco o	iven in Part		23h Did t	abacco una c	notribute to	the car	se of death?
P.0	ed by the detach		oo in bothing to doubt	Dat Inc. 1030king	ar the uncerty a	y cause y	IVOIT III T CIT.						4 ☐ Unknown
Vital Records,	been show							_	24a. Was a perfor		av co	ailable p	osy tindings nor to of cause
æ	The lev ate has pege 2								1 U Y	es 2 No	1[	Yes	2 No
Ita	yatclan: The s certificate director, peg To Be Co	25. Was case referred to medical axaminer?					26. Place	e of Death	(Check only or	10)			
0	7 00 5	1 Yes 2M No	Hospitat: 1 Inpet		utpatient 3	DOA O	ther: 4 No	ursing Hon	ne 5 Resid	ence 6 🗆 O	ther (Specif	y)	
	Attending Pindesh. ector: After the by the funeralification:	27. Manger of Death  1. Natural 5 Pending 2 Accident investigation		ay Year) 28b.	Time of tnjury M	28c. Inj W	ury at ork? ]Yes 2 []		8d. Describe h	ow injury occi	bernu		
Division	7475	3 Suicide 6 Could not to determined	286. Place of If	njury - At home, t dc. <i>(Specify)</i>	arm, street, tac	tory, office		2	ter. Location (S City or Tow		nber or Run	d Route	Number,
	within 24 hours a To the Funeral D completely filled I	29a. Certifier (Check only one) Certifying Pl	hysician: To the best miner: On the basis and manner s	of examination a	e, death occurr nd/or investigat	ed at the i	time, date an opinion, des	id place, a	and due to the o	ause(s) and r late and place	nanner as s o, and due to	tated.	se(s)
	within comp	29b. Signature and title of certifier	A even			29c. Licer	nse number	0		9d. Date sign	ned (Month,	Day, Ye	er)
		Needs the	ya M	dooth (trans co.)	(Turne Drint)	D	1380	9		Jan. 1	, 200	0	
		Neeta Ahuja, MD		th Washi		Stree	t Fa	11s C	hurch.	VA. 22	.076		
	State	31. Date filed (Month, Day, Year)		trays Signature	v 4		lac.	,					



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Decedent's Name (First, Middle, Last	)	Cer	tificate of	Death	2. Date of Deat	ng. No. 99	4	2596 3. Time of Death
Physician /Medical	Roy Wesl	ey Cutsail,	Jr.			Decembe	r 30, 19	<b>39</b> 9	12:40 PM
Examiner	4a Facility Name (If not institution, give Frederick Healt		r	4	Sb. City, Town, or Lo Frederic		4c. County o		ζ
Funeral Director	210-12-7909	7. Age (In yn 75	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 9	, 1924	9. Birthpli Count Mar	sce (State or Foreign Vland
styland show stat	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	cation		_		10	d. Inside City Limits
vith the Marylar or 28a-f show be notified at Director	Maryland Frederic	k Fr	ederick						1XXes 2□No
\$ 0.24 D	628 Wilson Pla	ce		10f. Zip Code 2170	)2	11	0g. Citizen of Wi U.S.A		ry?
2 2 2 2	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 XXIVO If Yes, Give XXIVO Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2√√No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race Black, Specify:	, White, e	
ed within 72 ho ygiens. wer then "neturn rt, the Medical. Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		1	ent's Usual Occup kind of work done NOT use retired nan/Carpe	ation during most of worki onter		16b. Kind of Bus		
d 2 should be filled within 72 hours at the and Mental Hygiens. 7 is marked other than "natural", or treumetic event, the Medical Exam To Be Completed by i	17. Father's Name (First, Middle, Last)  Roy Wesley Cu	tsail, Sr.	Total	iami / Carpe	18. Mother's Name Maude I	(First, Middle, M	Maiden Sumame		
C THE SEC. IN	19e. Informant's Name/Relationship (7) Mrs. Sylvia A. Cha		and the second s		and Number or Aura				
ermit. Pages 1 a Appartment of Hee Important: If Nem Iny Injury or othe SISS.	20a. Method of Disposition  **XABurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemovel from State	Place of Dispos cemetery, crem bunt Oliv	atory or other play	y, Jan. 4, 2		Frederi	*	Maryland
permit. Depart Importu any inj stics.	21. Signature of Funeral Service Licenti  Ruchard &  23a. Part 1. Enter the disease, or complete	MOO MOO	255 Ke		Basford				21.701
Physician /Medical Examiner	shock, or heart failure. List only or Immediata Cause (Final disease or condition resulting in death)	COPD	(or as a conseq	uence of):					Interval Between Onset and Death
eth certificate be executed strending physicien and for use as the buriel-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		(or as a consequ						
the ettending the for use a	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the ur	derlying cause giv	ren in Part I.	23b. Dld to	bacco use cont	tribute to	the cause of death
is that the death cert gned by the ettendin se deteched for use by Physician/N	DVT cardi	myopati	y d	cubete	Δ	104	ea 2□No	3 Prob	ebly 4□Unknow
The law requires that the death certilate has been signed by the ettending page 2 should be deteched for use Completed by Physician/M	renal insuff	ciency,	norma	pres	sure	24a. Was a parform	n autopsy med?	ava	re autopsy findings ilable prior to npletion of cause leath?
Com	hydro cepnal	45				1□ Ye	es 2 No	1 🗆	Yes 2□ No
Physicien: The this certificate ral director, page To Be Co	25. Was clase referred to medical examiner?  1 Yes 2 No	fospital:	☐ ER/Outpatien	3□ DOA Oth	26. Place of Death		ence 6 Other	r /Snecity	1
To the Hospital or Attending Physicien: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	26a. Date of Injury (Month, Day Year)		28c. Injur Wor			ow injury occurre		/
usi or Attending P rs sher death. el Director: Aftert led in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (SI City or Town	treet and Numbe n, State)	r or Rura	Route Number,
To the Hospital within 24 hours of the Funeral completely filled Medical Completely for the Funeral Completely filled Funeral Completely filled Funeral Completely filled Funeral Completely filled Funeral Completely filled	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	nician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tir estigation, in my o	ne, date and place, a pinion, death occurr	and due to the co ed at the time, d	ause(s) and man ate and place, a	ner as st nd due to	ated. the cause(s)
within To the comple	29b. Signature and title of certifier			29c. Licens			9d. Date signed	(Month, I	Day, Year)
	Drung			000	54705		Decembe	er 3	30, 1999
State Registrar	30. Name and address of person who or Katherine Buki 31. Date filed (Month, Day, Ken) 0.3	mpleted cause of death (Ite	grh 5	brint)	Frederic	u MD	2170	1	

DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 23, 1999 Fred 9:45 PM Vincent Cornwell /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth Month, Day, Year, Nov. 3, 1921 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number **Funeral** Days 10 M 2□ F 042-18-0477 **Director Uaual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Maryland Frederick 1 Xyes 2 No 288-19 Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 8 21701 2629 Caulfield Court 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Maritel Status permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hygiene. Important If Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examins 1 XYes 2 No If Yes, Give Year or Dates: 1943-1945 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2€ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Car Manager Automobile Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Cornwell Elizabeth Dorothy Fred Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8520 Inspiration Ave., Walkersville, Md. 21793 Mrs. Cindy Gallaway, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burlal 2 ☐ Cremetion 3 ☐ Removal from State Petersville, Md. St. Marys Church Cem., Dec. 28, 1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee <sup>22</sup>, Name end Address of Eacility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahook, or heer failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** stage Chronic Obstrative Luny Drocan /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. Ischemic Heart Dream 2/98 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To this 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 150 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 021944 MB

State Registrar

DHMH 16 Rav 6/95

300 W.

Frederick, md 21701

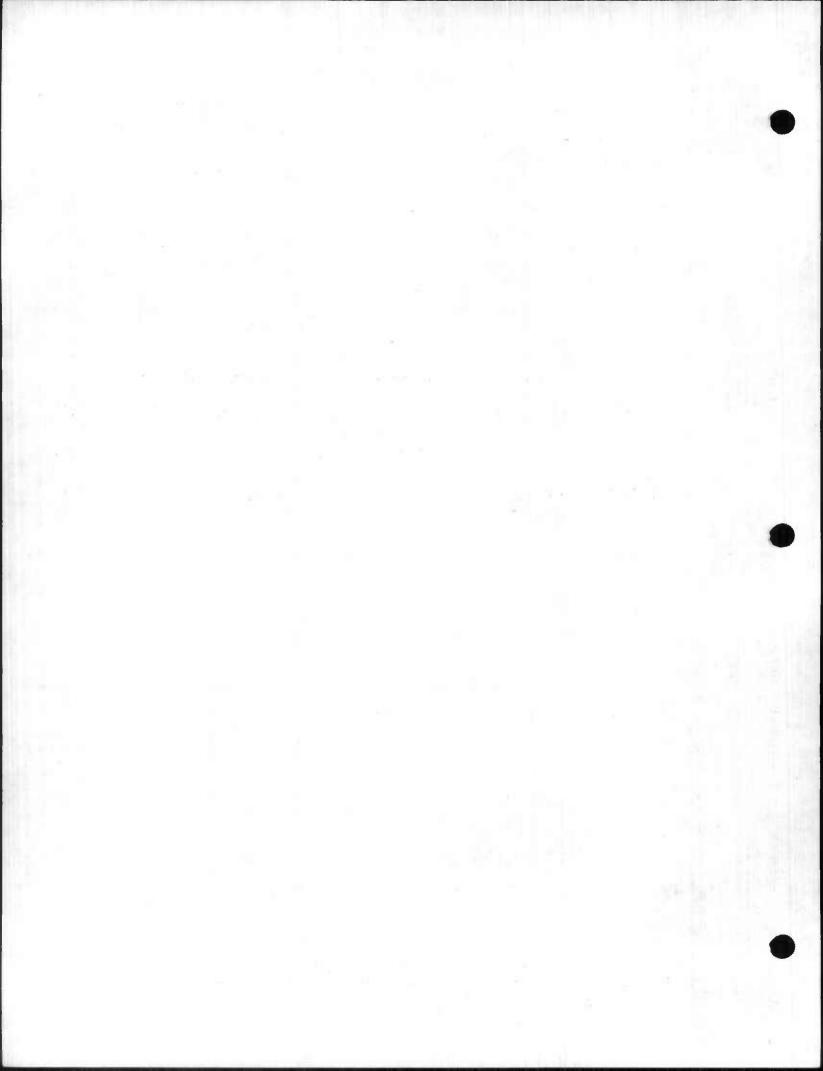
30. Name end address of parson who completed cause of death (Item 23a) (Type, Print)

Grisson

1999 >

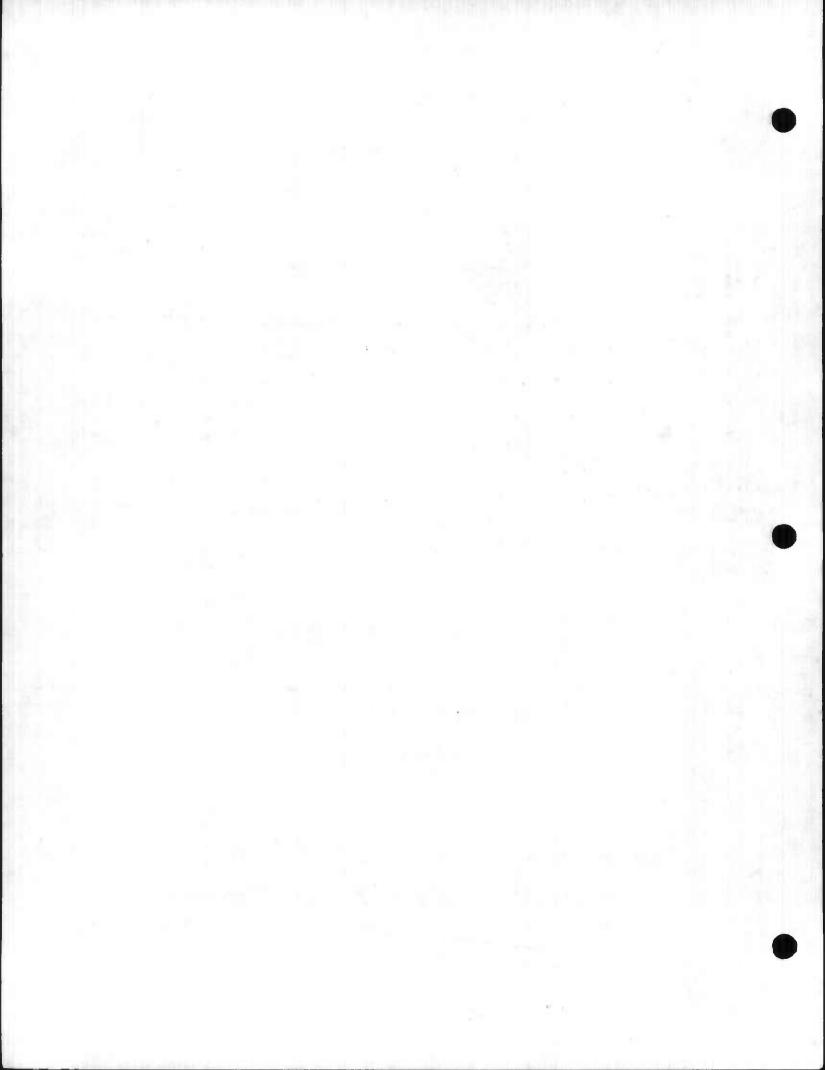
32. Registrarie Signature

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State of Maryland / Department of Health and Mental Hygiene

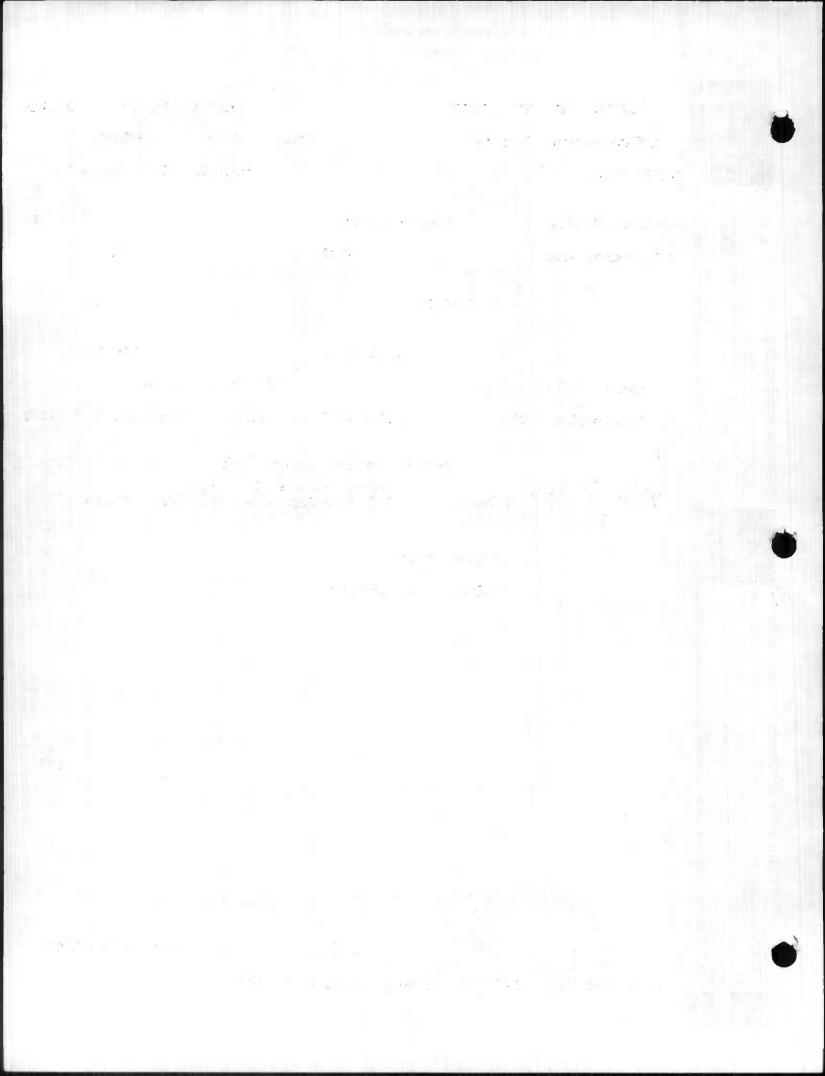
		Certificate o	f Death	Reg. No.	42598
Physician (Medical	Decedent's Neme (First, Middle, Last)     Audrey Bolton	Ciucci	2. Date of I	20, Day 1999 Year	3. Time of Death 11:45 PM
/Medical Examiner	4a Facility Nama (If not institution, give street and number) Northampton Manor Nursin	g Home	4b. City, Town, or Location of De Frederick	4c. County of Deeth Frederic	
Funeral Director	5. Social Security Number  229-03-7747  Contact Security Number  6. Sex 1□ M 2図 F 79  Usual Residence of Decedent	yrs. last birthday) If Under 1 Yes Months Day		Sirth Year) 1920 9. Birth	place (Steta or Foreign intry) 1 •
Director	10a. State 10b. County 10c	c. City, Town or Location			10d. Inside City Limits
be notified Director	VA. None	Richmond			Yes 2□No
rms 23a or 2 rmsst be n neral Dire	1713 Bellevue Ave.	10l. Zip Code	23227	U.S.A.	ntry?
France met	11. Marital Status  1 □ Never Merried 2 □ Merried  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes:	in U,S. 13. Was Decedent of If Yes, specify Ct	Hispanic Origin? (Specify Yes or I ban, Mexican, Puerto Rican, etc.) o Specify:	No- Black, White, Specify: Whi	, etc.
ygiene. ner than "naturn rt, me tendral Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	e during most of working	16b. Kind of Business/In	idustry
d d	Elementary/Secondary (0-12) College (1-4or 5+)	assembly pe	•	mfg. co.	
D . 0	17. Father's Nama (First, Middle, Last) Benjamin Thomas Bolton		18. Mother's Name (First, Midd Annie Mae Mill	lle, Maiden Sumame)	
PE	19a. Informant's Name/Ralationship (Type, Print) Carole M. Gropl (Daughter)	19b. Mailing Address (Stre	et and Number or Rural Route Num Hamburg, Germ		p Coda)
4 # 5	20a. Method of Disposition  A □ Burial 2 □ Cremation 3 □ Removel from State  4 □ Donation 5 □ Other (Specify)	Ob. Place of Disposition (Name of cometary, crematory or other process Lawn Ceme	pate 12/23	20c. Location - City or To Henrico, VA	
Department Important: eny Injury phes	21. Signature of Fungeri Servier ticensee		ress of Facility Thompson Funer in St., Middleto		59
Medical caminer  Medical Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	to (or as a consequence of):	scarciarine of	yeing	mortho
ettanding physicie I for use as the bui Clan/Medical	resulting in death) Last	to (or as a consequence of):			
by the sched	Part II. Other significant conditions contributing to death but not year.  Malentary			d tobacco usa contributa t	to the causa of death?
been si binode				rformed? av	Vere autopsy findings vailable prior to ompletion of cause I deeth?
certificate has rector, page 2.			10	Yes 2 No 1	☐ Yes 2☐ No
ector.	25. Was case referred to medical examiner?		26. Place of Death (Check only	y one)	
E P		2 LI EH/Outpatient 3 LI DOA	other: 4 Nursing Home 5 ☐ Re	e how injury occurred	(y)
within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	1 Waturat 5 Pending (Month, Day Year 2 Accident investigation	At homa, farm, street, factory, offic	Yes 2 No 28f. Location	(Street and Number or Run own, State)	rel Route Number,
in 24 hours he Funeral pletely filled adical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my cone)  Certifying Physician: To the best of my cone and mannar stated.	knowledge, death occurred at the mination end/or investigation, in my	time, date and place, and due to the opinion, death occurred at the time	e cause(s) and menner as a e, data and place, and dua t	stated. to the cause(s)
within 24 hours To the Funeral completely filled Medical C	29b. Signature and title of cartifier		26499	29d. Date signed (Month,	Day, Year)
	30. Name and address of person who completed cause of death  OF HONAY NITUEL FO	(Item 23a) (Type, Print) M7	AIR NO	21771	
State	31. Date filed (Month, Day, Year) 32. Registra/s S	ignature	1		



State of Maryland / Department of Health and Mental Hygiene

					Certi	ficate of	Death		Reg. No.	9 4	2599
		1. Decedent's Nama (First, Middla, La	esf)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physician /Medical	VITOLIS ANT	HONY DUOBI	LYS				DECEMB			10:34 AM
	Examiner	4a Facility Name (If not institution, give						Location of Deat			
101		Harford Memoria	l Hospital				TATIFICATION STATES AND ADDRESS.	le Grace	Ha	rford	
	Funeral Director		Sex 7. Age OXIM 2□ F	(In yrs. lest bir		If Under 1 Year Soriths Days	If Under 24 Hr Hours Mir		1938	Counti	ace (State or Foreign ry) uania
	land	10e. State 10b. County	Ì	10c. City, Town	n or Loca	tion				10	d. Inside City Limits
	h the Marylank r 28a-f show inoutled	Maryland Harford		Havre	de	Grace					1 ☐ Yes 2 ☐ No
	vith the Ma	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Count	ry?
	fier death with the result of the man to an Funeral Direction of the result of the res	1925 Chapel Road	l			2107	8			USA	
	ifter death v r items 23e	11. Marital Status	12. Was Decedent Example Forcas?	ver in U,S.	13. Wa	s Decedent of hes, specify Cub	Hispanic Origin? ( an, Mexican, Pua	Specify Yes or No rto Ricen, etc.)	- 14. Rac Blac	e - Amarica ck, White, a	
21215-0020	by	1 ☐ Navar Married 🏖 Married 3 ☐ Widowed 4 ☐ Divorced	1 ♥ Yes 2 □ No If Yas, Give Year or Dates: 1	957 <b>–</b> 81		Yes 2 No			Specify	Wh:	ite
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	al Hygie other ti vent, to	17. Father's Name (First, Middle, Last	2		Mode	1 Maker		ame (First, Middla			lenc
an	Dage m							(u/k)	Budzys	,	
Maryland	d 2 should be th and Mental 7 is marked or traumatic eve	19a. Informant's Name/Relationship (		19b	. Mailing	Address (Street		Rural Routa Numb		Stete, Zip (	Code)
X	tra tra	Ok Soon Duoblys									and 21078
re,	ges 1 and of Heal	20a. Method of Disposition		20b. Place of	f Disposit	ion (Name of tory or other ple	ice)	Date	20c. Location -	City or Tov	vn, State
E	4 H 9 B	Burial 2 Cremetion 3 4 Donation 5 Other (Specif						12-22-99	Aberde	en. M	arvland
Baltimore,	permit. Page Department of Important: If any Injury or once.	21. South and Funeral Service Lice	ns <del>op</del>	THALLUI	22. N	lame and Addra	ass of Facility				2 1 200 100
m	88558	Hiller K. IVI	11 mas					Home, P.A bad, Abir		iarv1a	nd 21009
		23a. Part1. Entermo disease, or com shock, or heart filure. List only	plications that caused to	he death. Do r	not enter	the mode of dyl	ng, such es cardid	ac or respiretory e	rrest,		Approximata Intervel Between
1	Physician										Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition	. Cardia	ac Arre	st						
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Y	od in		b. Myelor	ma - Pl	.asma	cytoma					
0,	rificate be executed no physician and as the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	D	ue to (or as a	conseque	nce of):				1	
68760,	ficate be physicial to the but edical	that initiated events resulting in deeth) Lest	D.	ue to (or as a c	conseque	nce of):					
9 ×	5 Dr di		d							i	
m	es that the death certigned by the attending be detached for use a by Physician/M							401 014			
P.O.	the d y the sched	Part II. Other significant conditions of	ontributing to death but	not resulting in	n the unde	erlying ceuse gr	ven in Paπ I.				the cause of death? ably (X) Unknown
-	igned be deta							- "	108 2 NO	3 Pion	abiy & olikilowi
Records	v requires that the been signed by the should be detacht should be detacht leted by Physical properties of the propertie								an autopsy	24b. Wei	re autopsy findings
000	as bee 2 sho							pond	med :	con	npletion of ceuse
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>	2 00	examiner?	Hospitai: 1 Inpatien	t 25 ER/Ou	utpatient	3 DOA Oti	har: 4 Nursing	Homa 5 ☐ Rasi	danca 6 □Oth	ar (Specify	)
n of	neral neral	27. Manner of Death 1 Natural 5 □ Pending	28a. Dete of Injury (Month, Dey		Time of	28c. Inju Wo	ry at rk?	28d. Describe	how injury occur	red	
Sio	eath. or: At the fu	2 ☐ Accident Investigatio				M 1	Yes 2 No				
Division	To the Heaptla or Attending Ph within 24 hours after death. Completely filled in by the funeral Completely filled in by the funeral Medical Certification: 1	3 Suicida 6 Could not b		y - At home, fa (Specify)	ırm, strea	t, factory, office			Street end Numl wn, Stete)	ber or Rural	Route Number,
	iled a Disa	200 004/200 200 004/200 00				4 - 4 - 4					and d
	n 24 hou n 24 hou ne Funer pletely fil	29a. Certifier Certifying Ph (Check only Medicar Exar	nysician: To the best of a niner: On the basis of a and manner state	my knowledge examination an	e, deeth o	ccurred at the ti stigetion, in my o	me, date and plac opinion, deeth occ	ce, and due to the curred at the time,	date end plece,	anner as sta and due to	the cause(s)
	Me ithin	29b. Signature and title of certifier		J		29c. Licans	sa number		29d. Date signe	d (Month, E	Day, Year)
'	- 3 <b>-</b> ŏ	10/	, Pala	1		D0018	1629		Decemb	er 20	. 1999
	11.	30. Name and address of person who	completed cause of de-	ath (Item 23a)	(Type Pri		, , , , ,		2000110		,
	1541	Rafig Patel,MD					od, MD 2	1040			
	State	31. Data filed (Month, Day, Year)	32. Registrar								
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Registrar **DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene 42600. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician HELEN PATRICIA DAVTS December 23, 1999 10:35 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) Aug. 28, 1938 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2K) F Yrs. 61 Director 220-34-7139 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nes 2□No Maryland Harford Aberdeen 288-1 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 6 Aberdeen Avenue 21001 USA Rams 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 Ho If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 20 Married 8 21215-0020 1 ☐ Yes ŽONo Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be sent of Health and Mental Scarborough Teslie Clara Mae Ernest Epperley 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health reportant: If Item 27 Is 6 Aberdeen Avenue, Aberdeen, Maryland Felix T. Davis, Sr. - Husband 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State Baker's Cemetery 12/28/99 Aberdeen, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License 22. Name and Address of Fecility McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that code of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on durin line. 21009 Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Due to (or as Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician the burle Physician/Medical for use as signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 16 3 Probably 4 Unknown þ Records, 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 : 1 Yes 2000 1 Yes 2 No certificata of Vital Attending Physician: 25. Was case referred to medicat examiner? 8 26. Place of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Donatient Certification: To 2 ER/Outpatient 3 DOA this funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 ENatural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide ò filled in 24 hours e Funeral D Hospital 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death 29a) (Type, Print) 32. Registra State

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Division Attending **Physician** 

1. Decedent's Neme (First, Middle, Last)

26**,** 1999 Margaret Maude Dill December 12:46 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Boonsboro Washington 8. Date of Birth (Month, Day, Year Jan. 28, 1 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) H Hoder 1 V **Funeral** Hours Davs Months 1□M 2XF 218-50-3717 91 1908 Director Jan. Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or frems 23a or 28e-f show any Injury or other traumatic avent, the Medical Examine Train be notified and after the page. 1 N Yes 2 No Director Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21755 USA 3819 Jefferson Pike Funeral 12. Wea Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 self homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) B Olie Burr Duvall Nettie Hammond Etchison 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bettye Herrell, daughter 3819 Jefferson Pike, Jefferson, Maryland 21755 20a. Method ol Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, Stete \*XBurial 2 Cremetion 3 Removel Irom State Arlington National Cem. 12/29/99Arlington, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licentine Keeney and Basford Funeral Home ~ MOO999 106 East Church Street, Frederick, MD 21701 23a. Perf1. Enter the disease, or complications that Aused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel SEPSI S disease or condition resulting in deeth) 3 days Examiner Due to (or as a consequence of): Since Examiner sician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial SURDURAC HRMATOMA Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yea 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evailable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. To the To the To the F 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number m. Kler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Waseem, M. Khalid, M.D. 10148 St. George Circle Hagerstown, Maryland 301-739-3750 8 1999 Flegistre's Signature State Registrar Spark

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

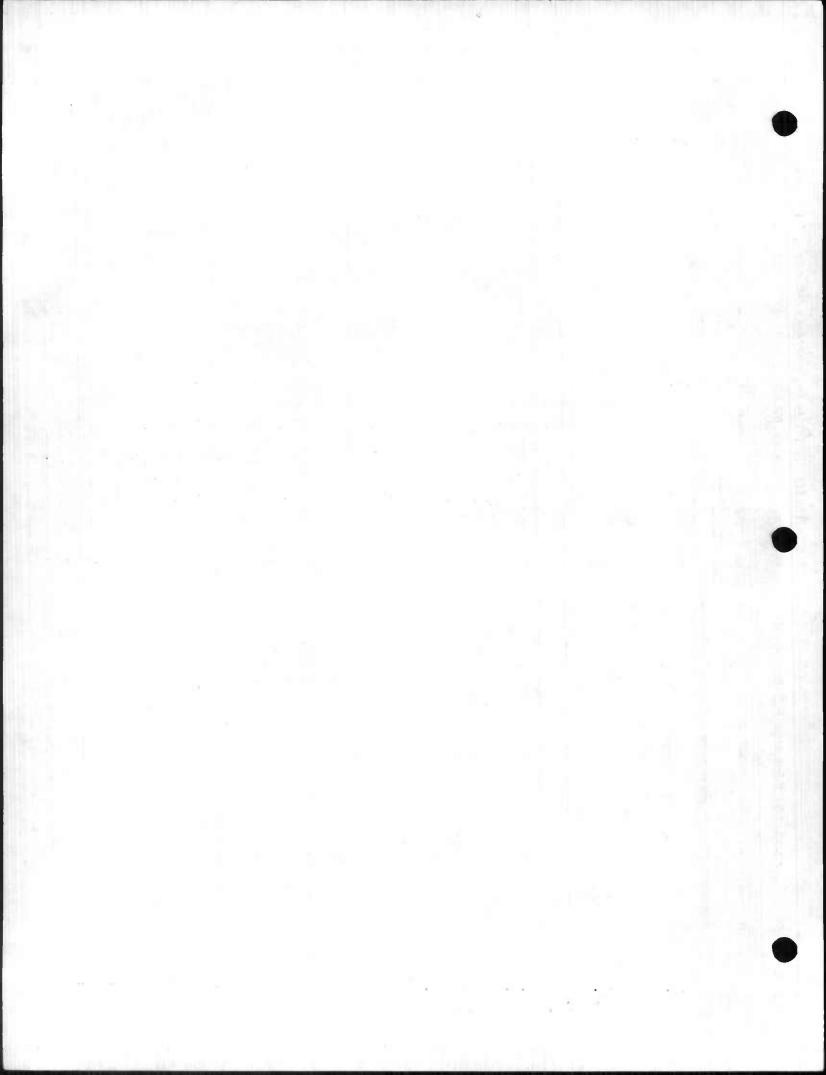
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**DHMH 16 Ray 6/95** 



State of Maryland / Department of Health and Mental Hygiene

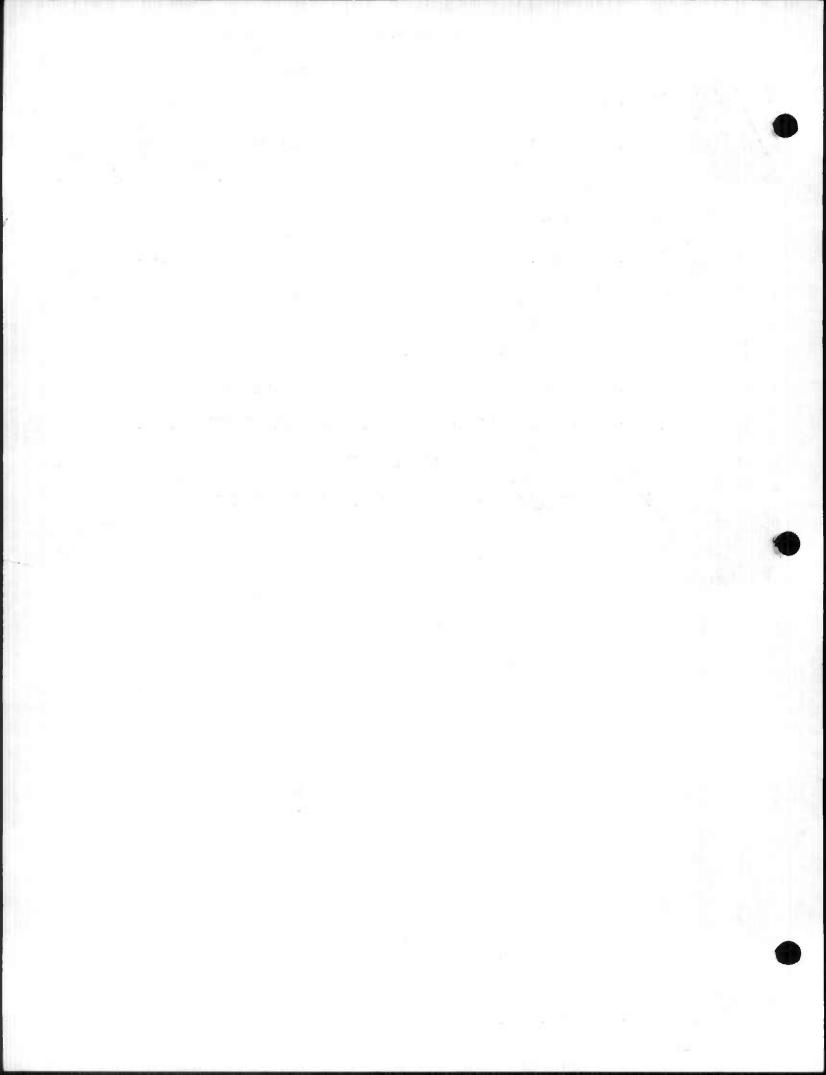
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth DECEMBER 24, 1999 **Physician** SISTER MARIE DONOHUE JULIE 2:55 A.M. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ST. CATHERINE'S NURSING CENTER EMMITSBURG FREDERICK If Under 1 Year Birthpiece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 X F Deys Hours Director 220-54-6872 WORCESTER, MA 101 MAR.13.1898 Usual Residence of Decedent the Meryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner number notified at 1 X Yes 2 □ No Director MARYI AND FREDERICK **EMMITSBURG** 10e Street and Number 10f. Zip Code 10g Citizen of What Country? SETON AVE. 331 S. 21727 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bieck, White, etc. 13. Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) filed within 72 hours efter 1X Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 271s marked other than any injury or other traumatic event. SISTER OF NOTRE DAME Elementery/Secondery (0-12) College (1-4or 5+) 5+ **TEACHER** 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be TIMOTHY DONOHUE 2 JULIA LYNCH 19e. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 331 S. SETON AVE., EMMITSBURG, MD. 21727 SR. MARY ADELE WHITE/SUPERIOR 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 D Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SISTERS OF NOTRE DAME 12/30/99 ELLICOTT CITY, MD. 21. Signature of Fujerel Service Licensee 22. Name end Address of Fecility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and ck, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Fine) diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Box 68760 O D cle Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 certificate 1 ☐ Yes 2 X No or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetlent 3 DOA After this funerel 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b Time of 28c. Injury et Work? 28d. Describe how triury occurred 1 X Neturel 5 Pending n 24 hours efter deeth.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) DECEMBER 24, 1999 30. Neme end eddress of person who wa 31. Dete filed (Month, Day, State Registrar

**DHMH 16 Rev 6/95** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42603

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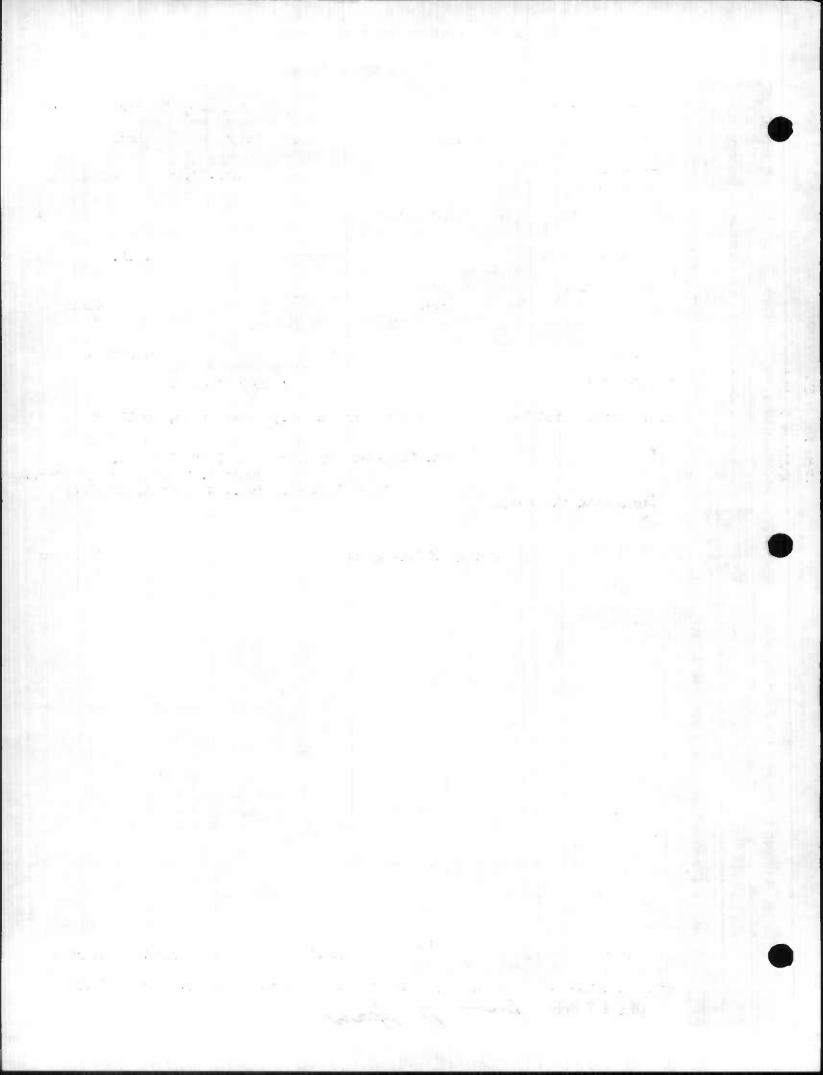
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ELIZABETH PAULA Month 3:45 A ELLIOTI 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Months 10 M 20XF Yrs. 212-20-8617 77 08/22/1922 Pennsylvania **Usual Residence of Decedent** 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Harford Havre de Grace 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Strawberry Lane Apt 2 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 | Yes 2 M No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece · American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Stock Person Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Ernest Verille Doquitzia Marte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominic Verille- Brother 1407 Superior St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/99 West Chester, PA R.A. Ferris & Co. Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Fart V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Fai fue 1 □ Yes 2 □ No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Completed by Physician/Medical Division of Vital Be Certification: To this Affar death. or Attend efter death Director:

**Physician** 

/Medical

Examiner

Directo

Funeral

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**Funeral** 

Director

altimore, Maryland 21215-0020

54:20

ELLIOTT

ELIZABETH

permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other treumatic even

Physician /Medical

Examiner

25. Was case referred to medical examiner?
1 Yes 2 No 27. Manner of Death

1 Natural

3 Suicide

29b. Signature and title of certifier

29a. Certifier (Check only one) 5 Pending

2 Accident 6 Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

1[S'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Hern 23a) (Type, Print)

1 ETICIA S. GALVEZ. M.D. 625 S. UNION AVE. HAVRE DEGRACE, M.D.

21078

State Registrar

edical

31. Date filed (Month, Day, Year)
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32. Registrer's Şignature

**DHMH 16 Rev 6/95** 

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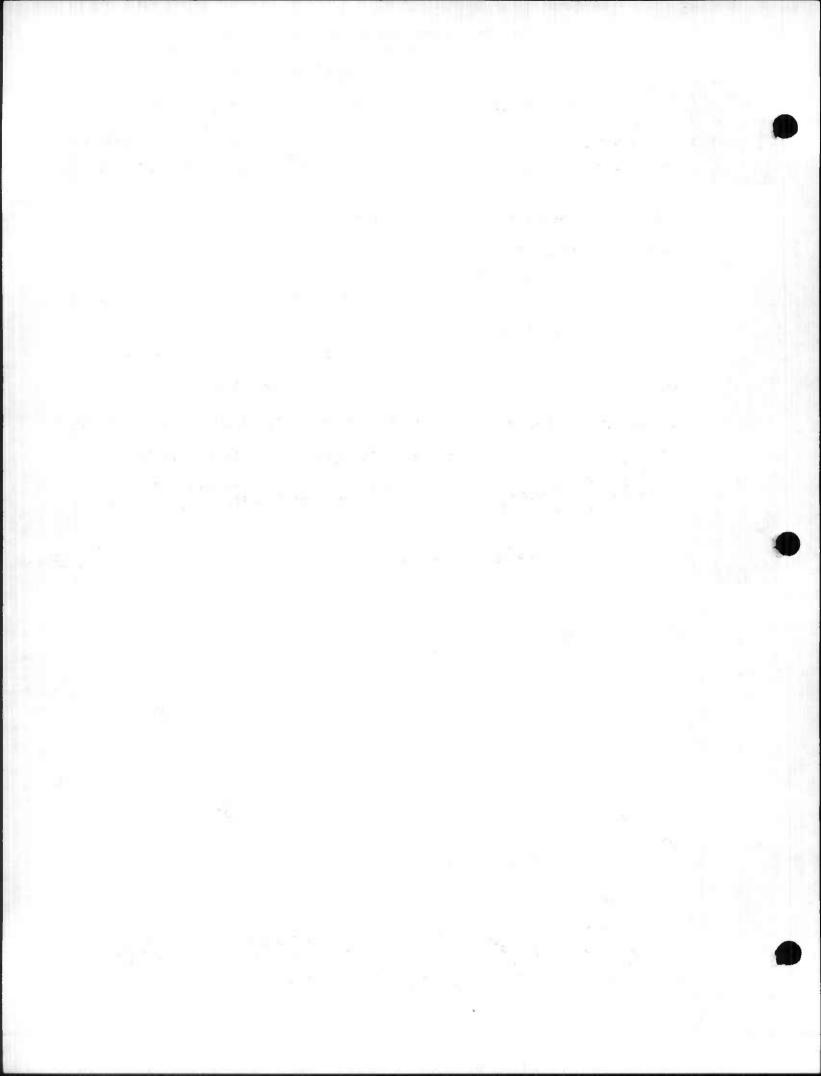
No. 1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Dec. 24, Day 1999 Year Small Eckert 4:20 AM Ruth /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4494 Pinewood Trail Middletown Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Jan 1920 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Coaptry) VA **Funeral** Deys 1□M 25 F 232-01-8802 79 Yrs. Director Usuel Residence of Decedant Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show man be notified at Funeral Director MD. Frederick 1 Yes 2 No Middletown 10e. Street end Number 10f. Zip Coda 10a. Citizen of Whet Country? 4494 Pinewood Trail 21769 U.S.A. Herns 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indien, Black, Whita, etc. traumatic event, the Medical Examiner 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 ò If Yas, Give Year or Detes: 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". 15. Decadent's Education (Specify only highest grede completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry end Mentel Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Omar H. Small Grace Mong 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health e Important: If Item 27 Is any injury or other training. 4494 Pinewood Trail, Middletown, MD. Cleo L. Eckert (Husband) 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Lutheran Cemetery 12/28 MIddletown, MD. 22. Name and Address of Facility Donald B. Thompson Funeral Home rvice Lic 31 E. Main St., Middletown, MD. 21769 esc. of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, so List only one cause in each line. Approximate eert failure. erval Between **Physician** /Medical Immediate Ceusa (Final disease or condition resulting in daeth) Examiner Dua to (or as a consequence of): Examiner ro the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has become completely filled in but the time. Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated evants resulting in daath) Lest Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2000 1 ☐ Yea 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of daath? Completed 24a. Was en eutopsy performed? 1 Yes 2 No Be 25. Was casa rafarred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA 5 Residenca 6 □Other (Specify) 28d. Describe how injury occurred Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Straet and Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, straet, factory, offica building, etc. (Spacify) 4 Homloide Certifying Phyafcian: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and manner as stated.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifian 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 31. Date filed (Month, Dey, Year) 32. Registra s Signeture State 1999 Registrar

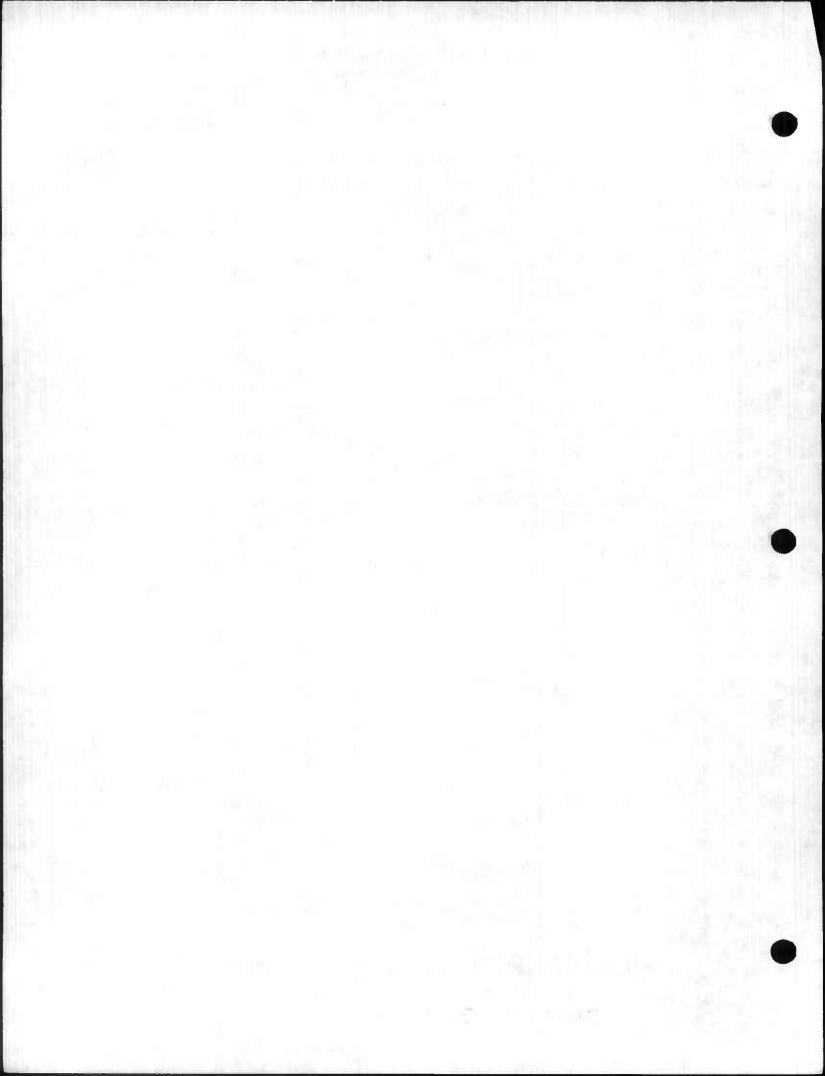


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Deeth 1 Decedent's Name (First Middle Last) 31, 1999 Month **Physician** 1:26 PM LOUIS MARTIN FRIESS December /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick 6. Sex-1 ☐ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 D . C . 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 215-38-5094 58 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show ust be notified at 1 Wes 2 No Maryland Directo Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be 102 Dogwood Avenue 21788 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ⑤ No If Yes, Give Year or Detes: 14. Reca - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) the Medical Examiner re-11 Merital Stetus filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking 17. Fether's Neme (First, Middle, Last) 18, Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fit ment of Health and Mental H bant: If Nem 27 is marked oth jury or other traumetic even Adam L. Friess Minnie May Pier 19a. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Patty A. Friess (Wife) 102 Dogwood Avenue, Thurmont, Maryland 21788 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removel from State artment ortant: If Blue Ridge Cemetery 1/4/2000 Thurmont, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Edge at Se 22. Name end Address of Fecility any le ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Pert1. Enter the disease, or complications that cannot is shock, or heart failure. List only one cause on each line and the doubt. Do not enter the mode of dying, such as cerdiec or respiratory errest, Approximete Interval Between Onset end Deeth Physician Immediate Cause (Final diseasa or condition resulting in deeth) /Medical **Examiner** Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es a consequença of) P.0. Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco uss contribute to the cause of death? 2 12 Yss 2 No 3 Probably 4 Unknown signed t þ Division of Vitai Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 should Be Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 XER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 2 Accident 5 Pending investigation after deeth. 1 Yes 2 No the 6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29e. Certifier completely and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (flem 23a) (Type, Print) Andrew Zarick, MD Rt. 40 1080 West Patrick Street, Frederick, MD 21702 31. Dete filed (Month, Dey, Year) 32. Registras Signature State JAN 04 2000

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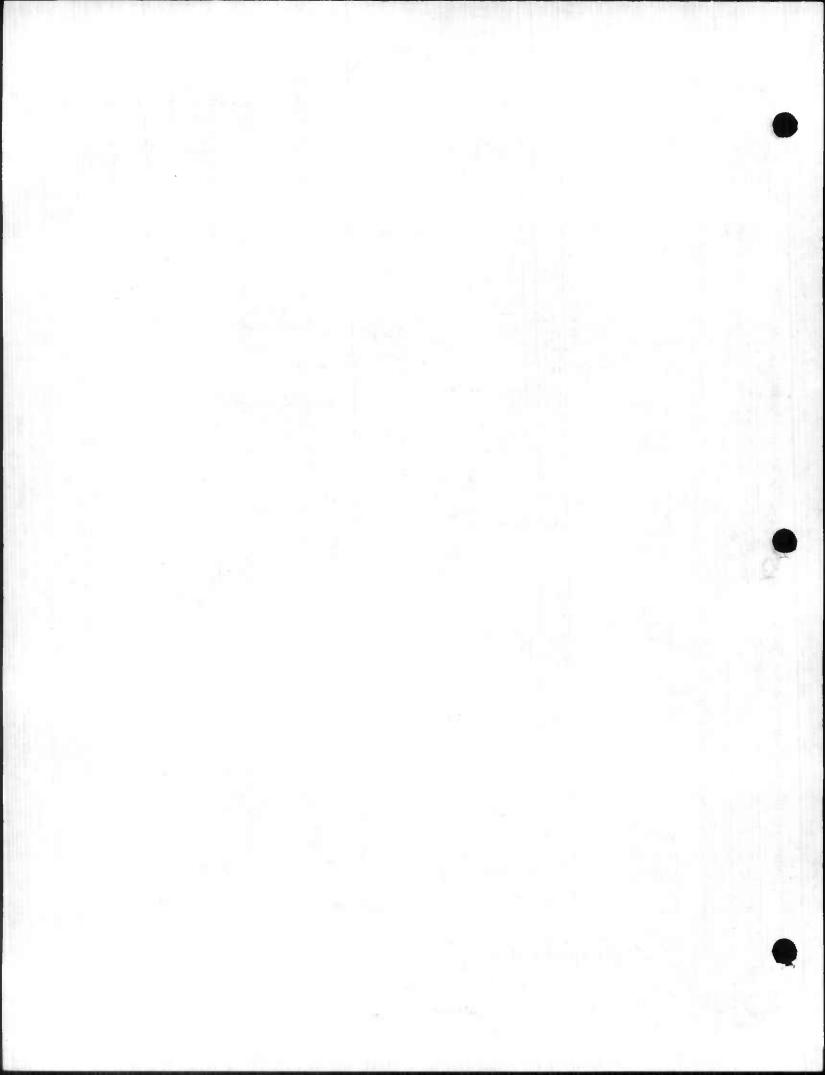


State of Maryland / Department of Health and Mental Hygiene

42608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **F**lanigan Month Marguerite **Physician** G. December 26, 1999 10:20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 F 93 Director 212-50-7585 Jan. 8, 1906 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits -how permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryle Department of Haeith and Mental Hyglens. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show shiply or other traumatic event, the Medical Examine must be notified as once. 1 Yes 2 No Directo Maryland | Frederick Keymar 10q. Citizen of What Country? 10e. Street and Number 10f. Zio Code 11629 Haughs Church Road 21757 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: P 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Grover Cleveland Marshall Myrtle Sarah Forney 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur A. Flanigan, Jr. 10018 Rocky Ridge Road, Rock Ridge, Maryland 21778 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Dec 1999 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Wellers U.M.C. Cemetery Thurmont, Maryland 22. Neme end Address of Facility 21 Signature of Funeral Service Licensee Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel phlumonia a disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner physicien and the burlei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ cate hes been significant page 2 should b 24b. Wera autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien:
 24 hours efter deeth.
 Funeral Director: After this cartifical letely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes Z⊠No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, Ierm, atreet, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as atated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 12/21/98 003/05 and address of person who completed cause of death (Item 23a) (Type, Print) 30, Name 200 Corner mine 1999 32. Replant Signeture 0200 RV. State

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State of Maryland / Department of Health and Mental Hygiene Q

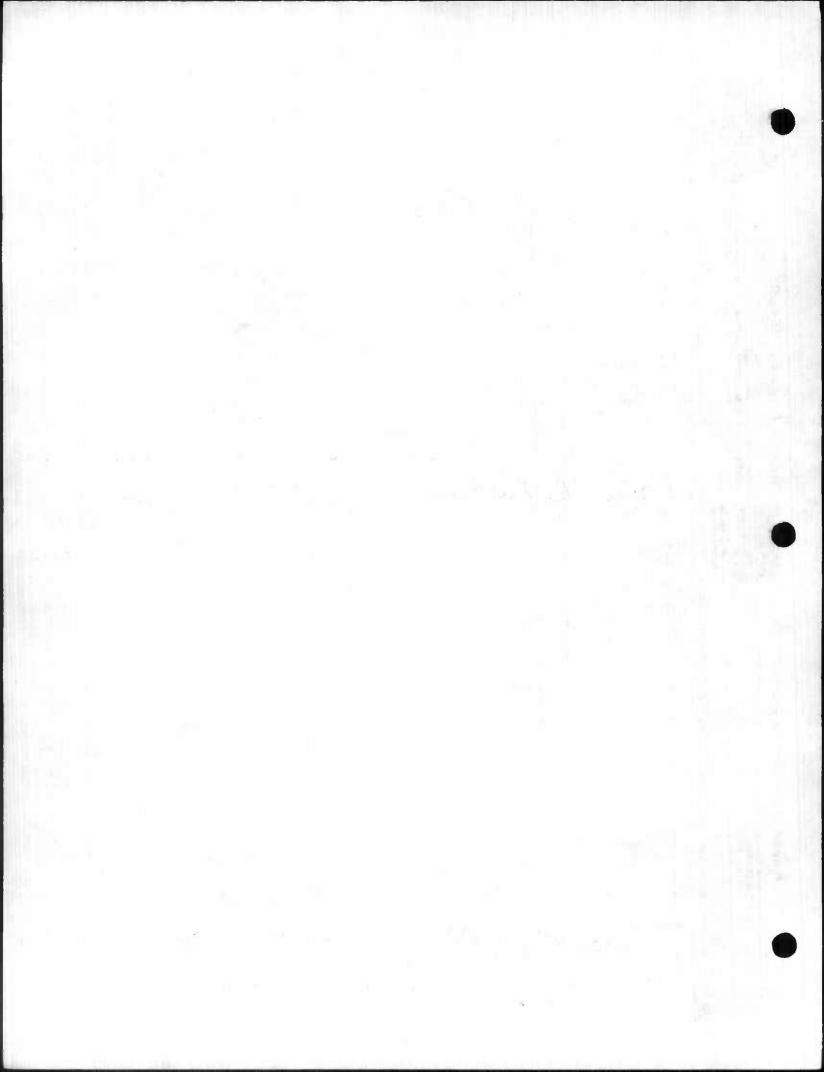
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Turner Furr December 24, 1999 7:47 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs. 229-32-8186 70 Director Jan. 7, 1929 Virginia Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Herne 23a or 28a-f show the Medical Examiner must be notified at Montgomery Maryland Gaithersburg 1 K Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17060 King James Way 20877 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 8 1 ☐ Yes 2 TNo Specify: White Specify: ğ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be fitted w. Department of Health and Mental Hygien Proportant: if Item 27 is marked other th. any Injury or other the Plumber Plumbing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Richard Mary Bellar 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 13741 Travilah Road, Susana Butt - Sister Rockville, Maryland 20850 20b. Piece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition cemetery, cremetory or other place) 1 Burial 2 □ Cremetion 3 □ Removel from Stete Monocacy Cemetery 12/29/99 Beallsville, Maryland 5 Other (Specify) 4 □ Donatie 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Acute Myocardial Infarction diseese or condition resulting in deeth) Minutes Examiner Due to (or es a consequence of): Examiner Coronary Artery Disease Years that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): and physician s the burial Box 68760 Physician/Medical Due to (or es a consequence of): 88 P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) he Hospital or Attending Phin 24 hours after death.

The Funeral Director: After the pletchy lilled in by the Iuneral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Metural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stelled. (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 20850 Thai McGreivey, M.D. SGAH - 9501 Medical Center Drive, Rockville, Maryland 31. Dete filed (Month, Day, Year) 32. Pa JAN 03 2000 32. Ragistra's Signature

State Registrar

DHMH 16 Ray 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month **Physician** 4c. County of Death Louis Ceasar Ganzzermiller cembe /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Levindale Hebrew Geriatric Center Baltimore City If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs 10XM 20 F 75 Director 03/04/1924 Maryland 217-18-0113 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maccal Examinar mant be notified at 1 ☐ Yes 2 ☐ No Director Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 143 Bayscape Drive USA 21903 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: by 3 Widowed 4 Divorced White Year or Detes: 1945-47 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 end 2 should be filed within 7 nent of Health and Mentel Hygiene. nrt: If Nem 27 Is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) 4th Assembler General Motors 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Ganzzermiller Margaret Yoss 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Department of Health ar Important: If Item 27 Is: any Injury or other trau once. 143 Bayscape Dr., Perryville, MD 21903 Sadie M. Ganzzermiller- Wife 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grd 12/31/99 Cockeysville, MD 22. Neme end Address of Facility 21. Signature of Funerel Service Licensee Mitchell-Smith Funeral Home, P.A. H 123 S. Washington, Havre de Grace, MD 21078 23e. Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ack, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last attending physicien and for use as the burial-tran Due to (or es e consequence of): 68760. 90 Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 10 Yaa 2□No 3 Probably 4 Unknown betructive à 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Mapner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? Certification: Affer 1 Division or Attanding 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner steted. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number and eddress of person who completed cause of deeth (Item 23a) (Type, Print) redere Ave Batto. No Wes theimer DD 31, Date filed (Month, Day, Year)

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State

Registrar

32. Registrar's Signature

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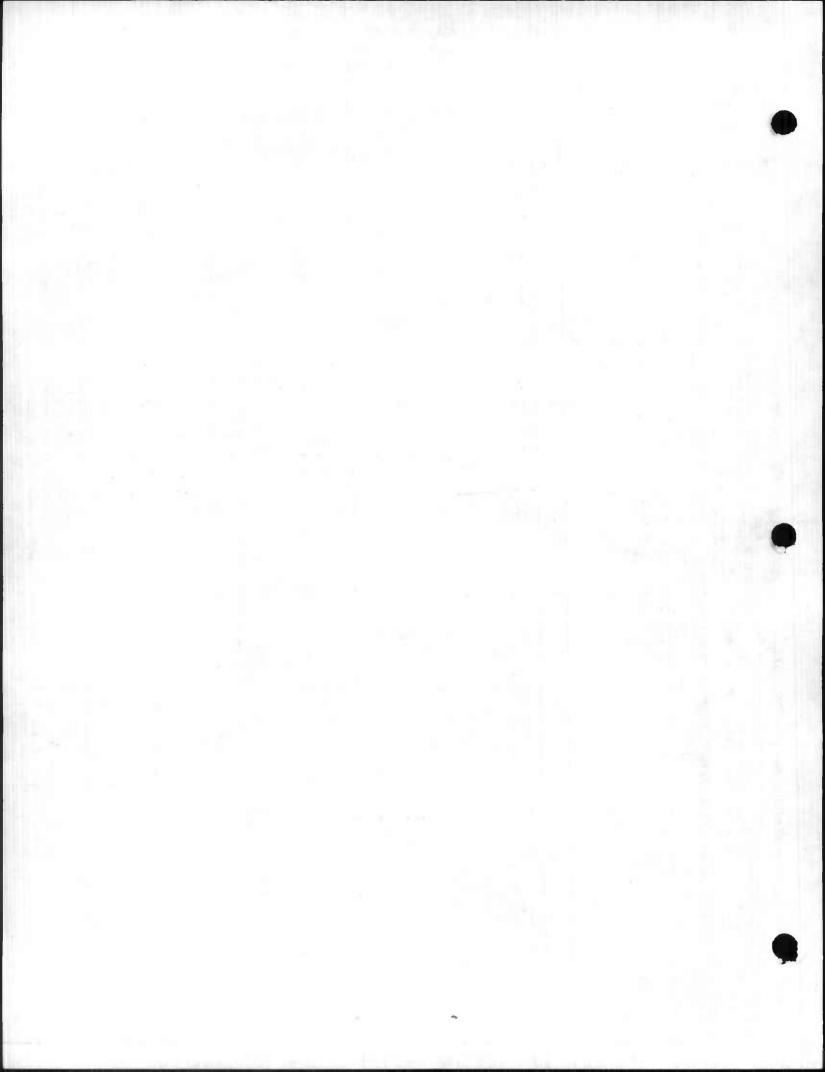
at the district of the state of

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** 6:00 P.M. 22, В. GANLEY 1999 December /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6140 Longbranch Road Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 217-12-1864 80 Director 30,1919 April Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. fnside City Limits ral", or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? To 6140 Longbranch 21701 Rd. United States Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itel any Injury or other traumatic event, tra Medical Examina 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: W.W.II Saitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Realtor Real-estate 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Joseph Hickman Ganley. Virgi 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Ganley / wife 6140 Longbranch Rd./ Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Mount Olivet Cemetery 12-24-99 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightee 22. Name and Address of Fecility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 Lerson Part of ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, should be referred to the cause of the Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner siclan and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physician for use as the buria Box 68760 Due to (or es a consequence of) P.O. 1 Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 (No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5/Q Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA edicai Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Neturel 1 Yes 2 No within 24 hours after death.

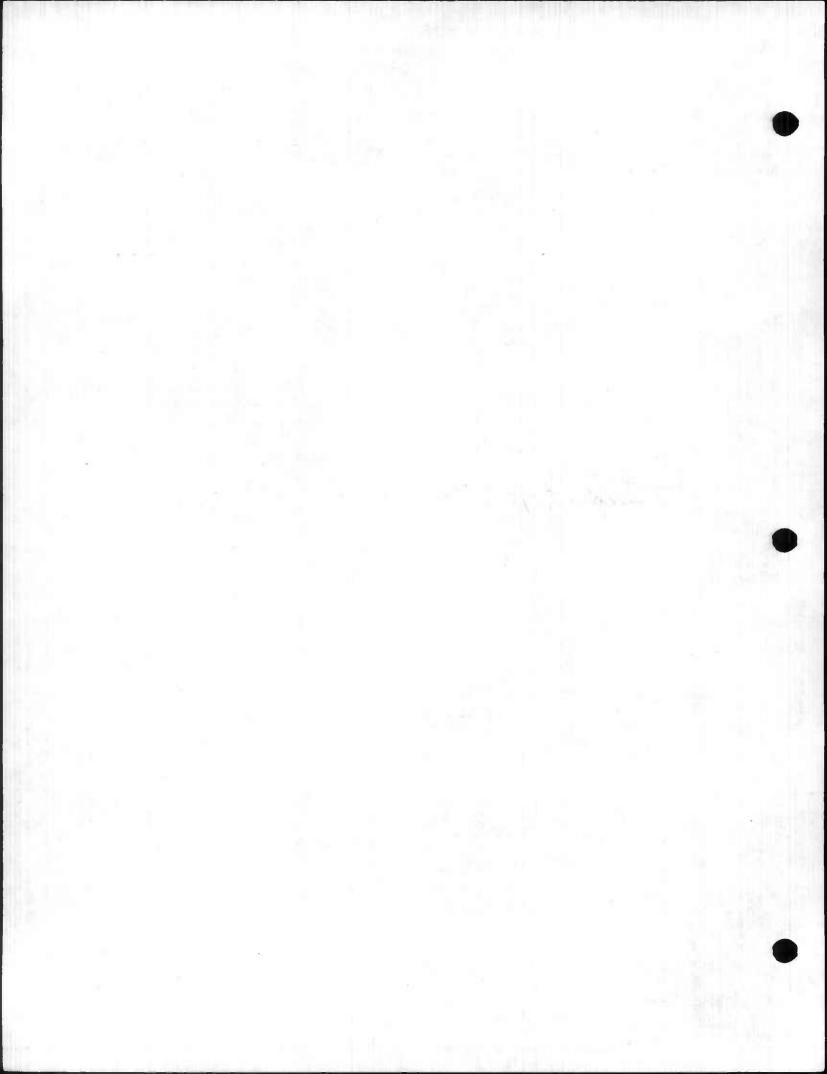
To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK SER HUN 310 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State DEC 2 7 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 1,2612

			Ce	rtificate of	Death	Reg	. No.	T time the T time		
Physician /Medical	1. Decedent's Name (First, Middle, Las Virginia Susan			7.		2. Date of Death Month	Dey 31 10	3. Time of Death		
Examiner	4a Facility Name (If not institution, give Washington Cou				4b. City, Town, or Lo Hagers to	wn		ington		
Funeral Director	2,, 0, 0,,0	7. Age (In yrs	. last birthday, Yrs.	Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) March 14	,1918 °	9. Birthplace (State or Foreign Country) Maryland		
with the Maryland a or 28a-f show Le notified at Director	Usual Residence of Decedent  10a. State 10b. County  Md. Was hin		ity. Town or L Hag	ocation erstown				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
th with the Ma 23e or 25e-f s ust be notified	10e. Street and Number 725 Interval Rd	•		10i. Zip Code	21740	100	g. Citizen of Wh			
er des Blams Describ	11. Marital Status  1 Never Married 2 Married  3 IX Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe ban, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)		- American Indian, , White, etc. White		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at operations of the lastin and Mental Hyghene. Important if their 27 is meriked other than "natural", or myoritant if their 27 is meriked other than "natural", or my injury or other traumatic event, the Medical Examinate.  To Be Completed by F	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		dent's Usual Occu kind of work done DO NOT use retir LCE WOTK	ipation e during most of worki ed)	ng	Sb. Kind of Busi			
d 2121 fled within Hyglena. ther than mrt, the Me	17. Father's Name (First, Middle, Last)		000	cce work	18. Mother's Name					
Aland Mental Hrked old the even	Dwight D. Dunkel				Leah Bel		10.00			
B, Marylan and 2 should be teath and Mental m 27 is marked or her traumatic or	19a. Informant's Name/Relationship (7) Lynda S. Socks	(Daughter)			rs on Blud.					
altimore, Millimore, M	20a. Method of Disposition  1 Bullat 2 Cremation 3 Disposition  5 Other (Specify	Removed from State	cemetery, cre	osition (Name of matory or other place) TG Chema	tory Jan.			ity or Town, Stata		
Balt permit. Depart importu	Signature of superet Strice License	Plans	0	2. Name and Addi	eral Home	12525 Bru Smithsbu	adbury	Aue.		
Physician /Medical Examiner pure us pu	23a. Fart1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	. Aute		CAVdi	M In			Interval Between Onset and Death		
C 6876	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Last	c	or as a consec							
P.O. Box set the death cent dby the attending establed for use	Part II. Other significant conditions co	ntributing to death but not ra	sulting in the L	inderfying cause o	iven in Part I.	23b. Did tob	acco use cont	ribute to the cause of death?		
P.O. that the detached of Physics		structive	Disease	3 Probably 4 Unknown						
BCOrd  Bw requir  2 should						24a. Was an performe		24b. Were autopsy findings available prior to completion of cause of death?		
Vital Rule Rule Rule Rule Rule Rule Rule Rul	25. Was case referred tel medical				26. Place of Death	1 Yes		1 Yes 2 No		
- 5 .00 E	examiner?	Hospital: 1 Inpatient 20	ER/Outpatie	nt 3 DOA	ther	me 5 Residen		(Specify)		
On O	27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	ury at 2 ork? ☐ Yes 2 ☐ No	28d. Describe how	Injury occurred	d		
V Attendent therdest in by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Stre City or Town,		r or Rural Route Number,		
Hospit 24 hour Funeri stely filli	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the livestigation, in my	time, date and place, a opinion, death occurre	and due to the cau ed at the time, date	se(s) and mane e and place, ar	ner as stated.  nd due to the cause(s)		
To the within To the compile	29b. Signature and title of certifier  Duc J.	neli.			2652	3 290	J. Date signed (	(Mopth, Day, Year)		
	30. Name and address of person who co	D) OV+DS	MO	Print) //// /	Medica	1 CAMP	USIZOA LAGEIZ	Stone 21792		
State	31. Date filed (Month, Day, Year)	32. Flegistrar's Sign	ature 4	lan	,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #4a, 1/3/00, CWC, Kent County Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Thomas Willing Huber 30 December 1999 2145 /Medical 4e. Facility Name (If not institution, give street and number) 201 Water Street 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** The Kent and Queen Anne's Hospital Inc. Chestertown If Under 1 Yeer Months Devs 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys ₩ M 2 F Hours Director 180-16-8387 Usuel Residence of Decedent May 22,1924 Pennsylvania the Maryland 10e. Stete 10c. City, Town or Location 10b. County permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental thygiena. Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, its Mental Examine must be notified at any injury or other traumatic event, its Mental Examine must be notified at 10d. Inside City Limits 1 Yes 2 No Chestertown Director Kent Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21620 201 N. Water Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Maritei Stetus Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Saltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: WWII 1 ☐ Yes 2 ☐ No by Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Antique Antique / Decorating 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mary Hays Joel Cook Huber 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 201 N. Water St. Chestertown, Md. 21620 Mary Savage Huber 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c, Location - City or Town, Stete 1 ☐ Buriei 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Cremation Cntr.12/31 | Stevensville, Md. 21. Signeture of Puneral Service Licenses 22. Name end Address of Fecilis Fellows, Helfenbein, and Newnam Funeral Hm. 130 Speer Rd. Chestertown, Md. 21620 778-0055 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) to Head /Medical Grun Shot Wound < 150C Examiner Due to (or es e consequence of) Examiner ician and buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequença of) physician at the buriel Box 68760. Physician/Medical Due to (or es e consequence of): attending signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Major Depression à Chronic Obstructue Pulmonay Disease 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed hes Fibrillation flutter-26 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 2 After this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Feat) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurre Certification: al or Attending F s after deeth. SINS PM 1 Naturel 5 Pending Gun Shot 1 Yes 2 No 2 Accident
3 Suicide investigation 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State)

Chestudoum MD @ F 4 Homicide Home : Garage To the Hospital or within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner stated. 29a, Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Dete filed (Month, Dey, Year)

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30. Name and address of person who co

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82. Registrer's Signeture

MD

Road

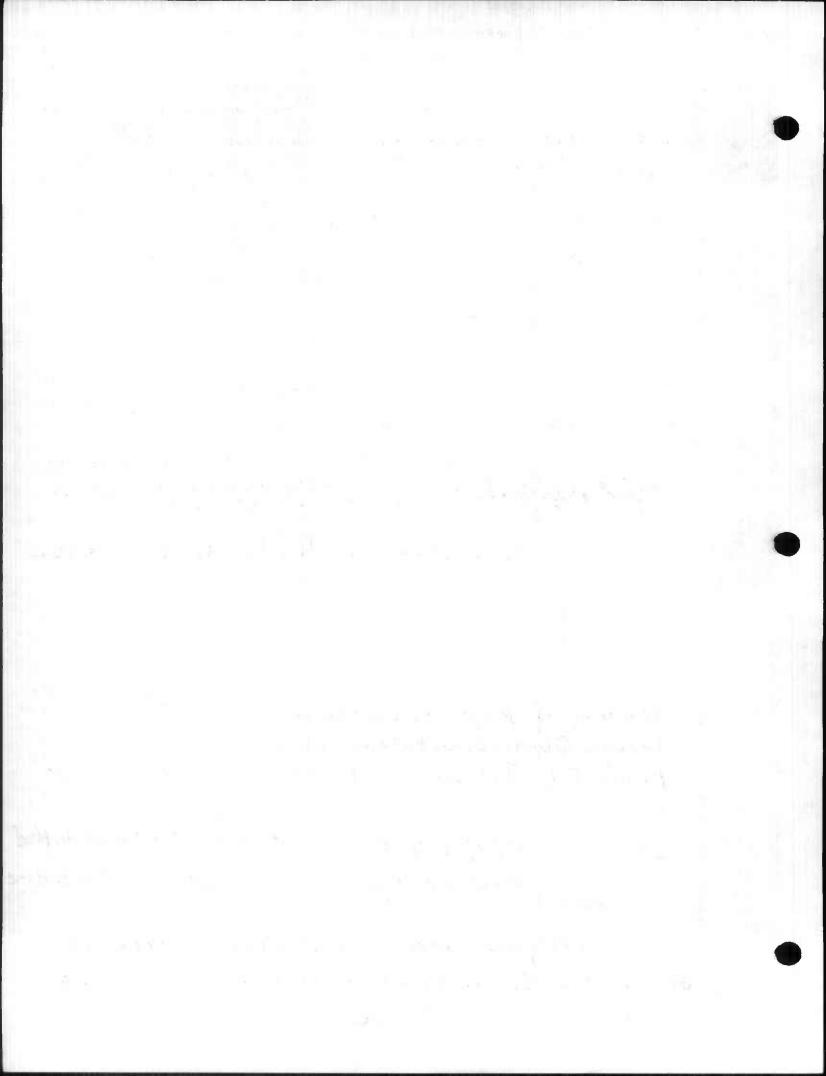
pleted cause of deeth (Item 23e) (Type, Print)

Sparks!

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hestentown

MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death December 27, 1999 **Physician** 9:25 a.m. Mary Ruth Hannold /Medical 4a. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner Heron Point Chester co...

If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
Anoust 9, Kent 5. Social Sacurity Number If Under 1 Year 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** 1□M 2XF Months Days 142-36-6874 92 Vrs Director 1907 Baltimore, Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show 10d. Insida City Limits 1 X Yes 2 □ No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10003 Heron Point 21620 USA Funeral 7 is marked other than "natural", or items traumatic event, traumatic event, 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ( Hygiene. ther than "natural", or Iter 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 No Spacify: Completed by White 3€ Widowad 4 Divorced Specify 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Ownhome Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 and 2 should be filt ment of Health end Mental Hant: If item 27 is marked oth fury or other traumatic even Charles S. Holt Bertie Ford 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Ruth Talley/Daughter 19 Mantua Road, Mt. Royal, NJ 08061 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 Burial 2 Cremation 3 Namoval from State Depertment of important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Eglington Cemetery 12/30/99 Clarksboro, New Jersey 21. Signatura of Fune Service Licansee 22. Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between **Physician** /Medical Immediate Cause (Final CONGESTIVE HEALT FAILURE disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760, ettending physician for use as the bune Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the undariying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown WITH KNEE FRACTURE DSTEUPORUSIS þ Completed 24e. Was an autopsy performed? 24b. Were eutopsy findings available prior fo SEVERE DSTEDARTHRIMS completion of ceuse of death? 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Am A Mobile 41587

Registrar

DEC 2 8 1999

31. Date filed (Month, Dey, Year)

12 Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620 32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

gu it well

D41887 12/21/19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 21, 1999 11=53PM Texie (nmn) Holloway 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c County of Death Harford 911 Pine Road If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Days 1 M 3 F Yrs. Feb. 26, 1907 N. Carolina 212-28-0416 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Insida City Limits 1 Yas 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 911 Pine Road 21085 TISA 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Yes 22 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 N Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middle, Last) Harriet (nmn) (unknown) Henry (nmn) Casey 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Pine Road, Joppa, MD 21085 Sylvia Day/ Daughter 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 12-23-99 Bel Air, Maryland 21. Signatu Funeral Service Licens 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Effer the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth ANTEMO SULENOTIC tmmediate Ceuse (Finel ASCVA disaasa or condition resulting In death) Due to (or es e consequence of): AND WAN WIAR DISEASE Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 21 No 1 Yes t□Yes 2 No 25. Was case reterred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28b. Time of

**Physician** Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Works !

Director

Funeral

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Completed

Be

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death with the Meryland

filed within 72 hours effer

al Hygiene.

Peges 1 and 2 should be nent of Health and Mental int: If item 27 is marked o

permit. Peges 1 and 2: Department of Health ar Important: if item 27 is any injury or other traughter.

3altimore, Maryland 21215-0020

Examiner Physician/Medical ۇ م Completed Be 2 Certification:

certificate be executed ettending physician and for use as the burial-tran P.O. signed by t peed certificate Division of Vital Mospital or Attanding Physician:
 24 hours efter death.
 Funeral Director: After this certifics To the Hosp within 24 ho To the Fune completely fi

W

Medical

28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation 3 Suicida 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

(Check only one)

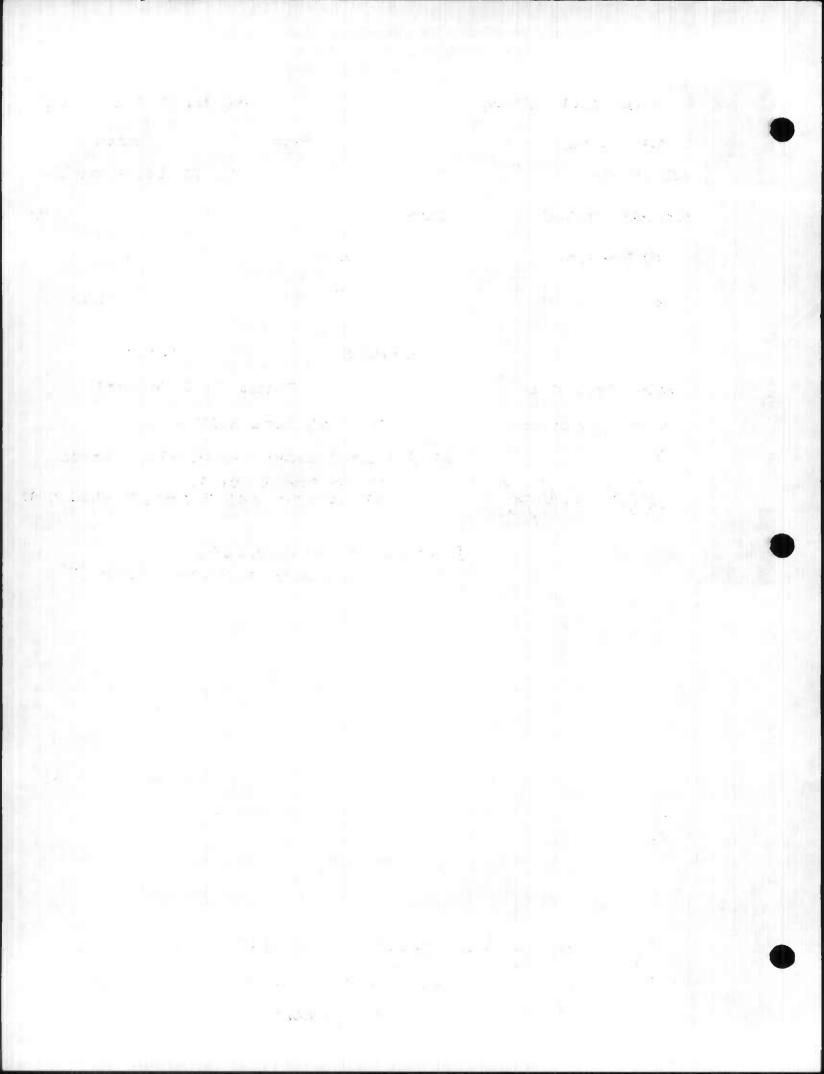
22 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29d. Date aigned (Month, Day, Year) 29c. I Icense number

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

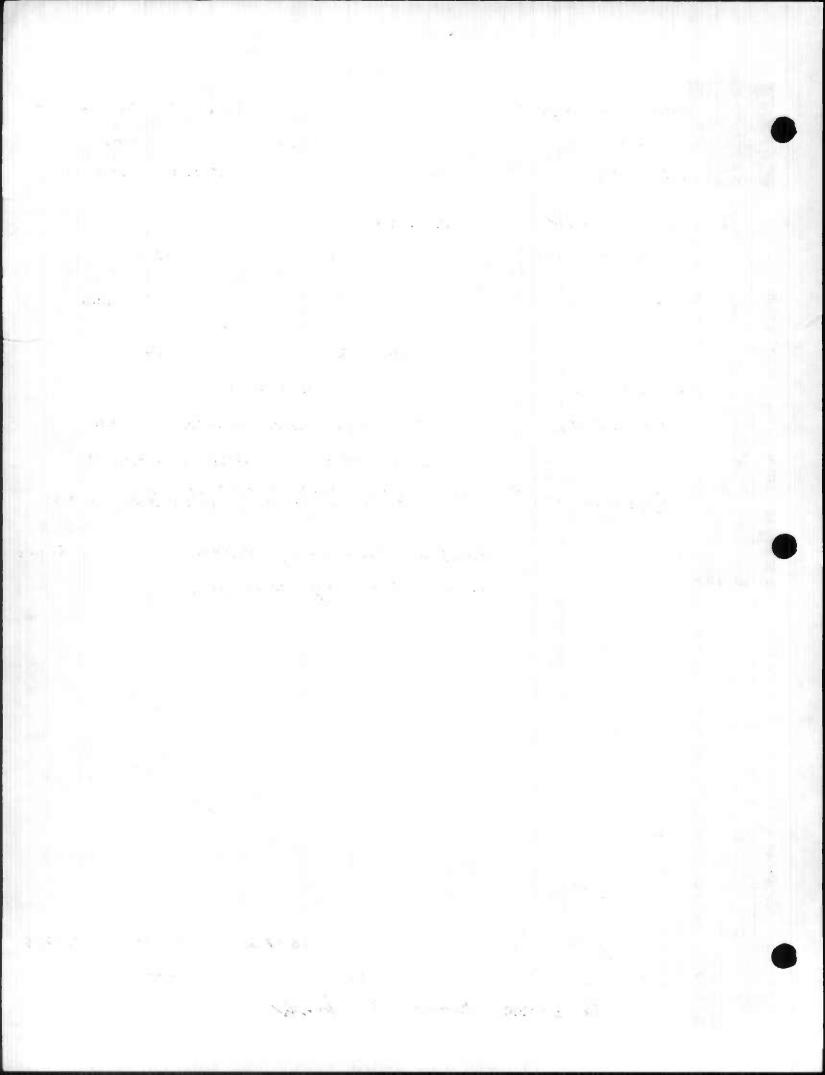
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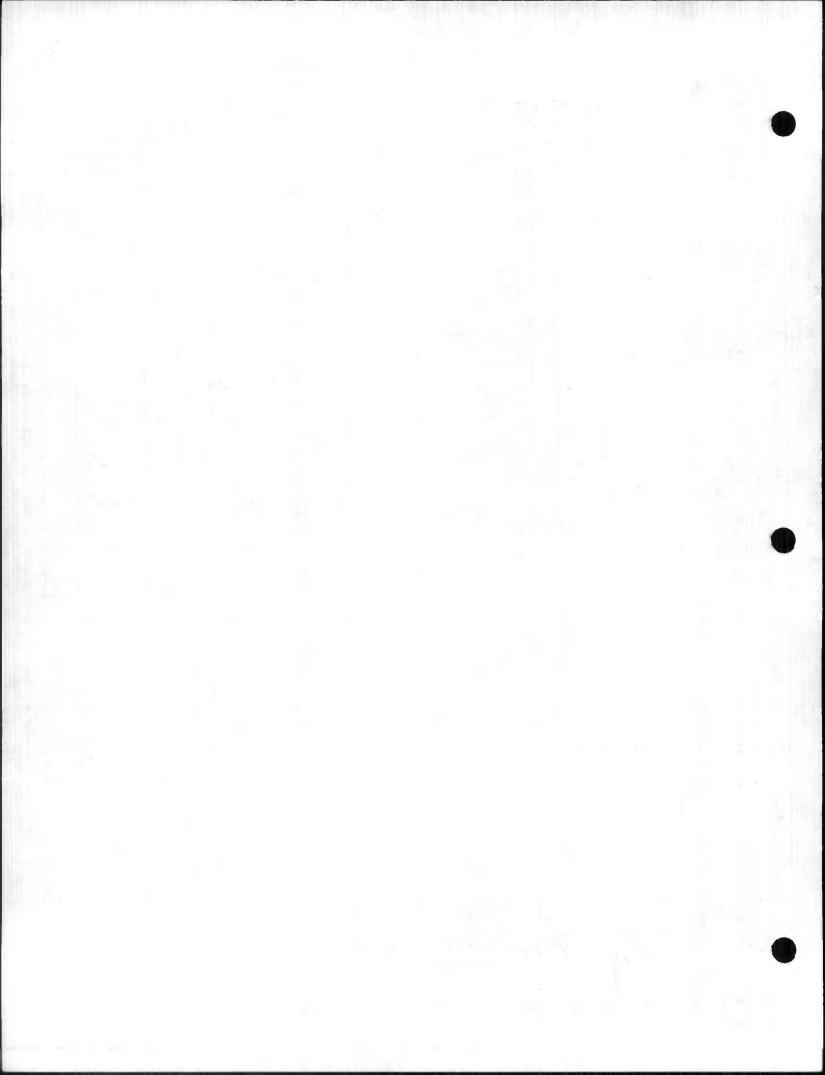
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r thems 234	11. Marital Status		12. Was Decedent	Ever in U,S.	13. Wes Dec	edent of Hi	spanic Origin?	(Specify Yas or No-	14. R	ece - Americ		
Fui Fu	1 Never Me	erried 2 Merried	Armed Forces?	No				erto Rican, etc.)		leck, White,	atc.	
el". o	3 XWidowed	4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 L Yes	21X No	Specify:		Spec	<sup>cify:</sup> Wh	nite	
s 1 and 2 should be filed within 72 hours eft if Health and Mental Hygiene. Item 27 Is marked other than "natural", or other traumatic event, the Medical Event To Be Completed by F	(Sp	15. Decedent's Ed	1	16e. Decedent's Us		ation during most of w	vorkina	16b. Kind of	Business/In	dustry		
e 0 20 and	Elementary/Se			College (1-4or 5+)			)					
od w	11	th			Homem	aker			Hon			
permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, tha Media.  To Be Compi	17. Fether's Nem	e (First, Middle, Last)	1					ieme (First, Middle,	Meiden Sum	ame)		
d 2 should be file th and Mental Hy 7 is marked othe traumatic event To Be C							Dora J					
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Medical	Ceuse (Disease thet Initiated ever resulting in death  Part II. Other elgr  25. Wes case refexaminer?  1 Yes 2[  27. Menner of De 1 Naturel 2 Accident 3 Sulcide 4 Homicide  29e. Certifier (Check only one)	erred to medical  PNo  eth  5   Pending investigation 6   Could not be determined  1   Certifying Ph 2   Medical Examed title of pending	d	Due to (or estable to the property of my knowled examination at ed.	s a consequence of s a consequen	OOA Other Section of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time on, In my of the time of time of time of the time of time of time of time of time of time of time of time of tim	26. Place of Der: 4   Nursing at Yes 2   No ne, dete end ple binlon, deeth occ a number</td <td>23b. Did to the courred et the time, of</td> <td>en eutopsy mad?  Tes 2 No ne)  Tence 6 Cow injury occurrent end Null  Tence 10 No ne)  td> <td>24b. We ever confidence of the</td> <td>fere autopsy finding reliable prior to mpletion of cause death?  Yes 2 No  No  No  No  No  No  No  No  No  No</td>	23b. Did to the courred et the time, of	en eutopsy mad?  Tes 2 No ne)  Tence 6 Cow injury occurrent end Null  Tence 10 No ne)	24b. We ever confidence of the	fere autopsy finding reliable prior to mpletion of cause death?  Yes 2 No  No  No  No  No  No  No  No  No  No	
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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 23, 1999 **Physician** Dorothy Louise Harmeyer December 9:00 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5934 Serenity Lane Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 2, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□ M 2₩ F 220-20-7414 87 Yrs. Maryland Director Usual Residence of Decedant the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or frams 23a or 28a-f ahow 1 Yes 3€ No Rockville Director Maryland Montgomery 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? with 20855 USA 5934 Serenity Lane Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ⊆ to No If Yes, Giva Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer of order of Health and Mental Hygiene.
Iff flem 27 la marked other than "naturel", or fles into order treumatic event, the Medical Engineer. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White P 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 8 William Elizabeth H. Lomyer Suzanne Venzke 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5934 Serenity Lane, Rockville, MD 20855 Patsy H. Herberg/Daughter 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Peges Department of Important: If it eny injury or o Trinity Lutheran Cem. 12/29/99 Joppa, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Years Myasthenia Gravis Examiner Due to (or as a consequence of). Physician/Medical Examine physician and the burief-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Due to (or es e consequence of): 80 980 P.O. Part ff. Other significant conditions confributing to death buf not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Records. þ The law requires 50 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Hypertension page 2 1 ☐ Yes 2XXNo 1 ☐ Yes 2 ☐ No of Vital or Attending Physicien: 25. Was case raferred to medical examinar? funeral director, 8 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation 1 Yas 2 No 24 hours effer death. the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a. Certified 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated er: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner steted. (Check only one) 2 Medical Exam within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D08381 December 23, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Avrunin, M.D., 18111 Prince Philip Dr., #209, Olney, Maryland 20832 31. Date filed (Mor) 32. Registrar's Signature State souls!

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Rebecca Holland Tnez. Dec 31 1999 12:50 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Genesis ElderCare Easton If Under 24 Hrs. Talbot The Pines
7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaar) OCT 17, 1910 If Under 1 Yeer 9. Birthplece (State or Foreign Country) Mount Airy, MI **Funeral** 1□M 2AF Months Deys Hours Min 220-10-5395 89 Director Usual Residence of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Talbot Easton Maryland 1 Nas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8176 Ethan Avenue 21601 U.S.A. Funeral pernit. Pages 1 end 2 should be filed within 72 hours efter death N Department of Heelth, end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23 any lijury or other traumatic event, the Medical Experiment must pings. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yaar or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Merried 2 Merried altimore, Maryland 21215-0020 White 1 Yes 2X No Specify: PV 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home Holland 6 18. Mother's Name (First, Middla, Meiden Sumeme) 17. Father's Nema (First, Middle, Lest) Edward Watkins Bertha Condon 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent'a Name/Raletionship (Type, Print) Gloria I. Finn/Daughter 8176 Ethan Avenue, Easton, Maryland 21601 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from State Mt Olivet Cemetery Jan 5, 2000 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fecility 21. Signeture of Funerel Servica Licansee Keeney & Basford P.A. Funeral Home 10epon M00706 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. 106 East Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediete Cause (Finel weeks disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner ettending physicien end for use es the burial-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): P.O. 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 3 Probably 4 Unknown 3 1 Yes 2 No leky dralion Division of Vital Records, by 8 24b. Were eutopsy findings aveilable prior to 24e. Was an autopsy performed? Completed completion of cause of deeth? has 1□ Yes 🔏 No 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No O<sub>L</sub> 1 Inpatient 2 ER/Outpatlent 3 DOA 28c. Injury at Work? funerel 28d. Describe how Injury occurred 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Certification: or Attending F effer deeth. Director: After 1 Naturel 5 Pending 2 No 1 Yes 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D edical 29a. Certifier Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. Licanse number 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) JASTON, MD 21601 508 CROWLEY WD

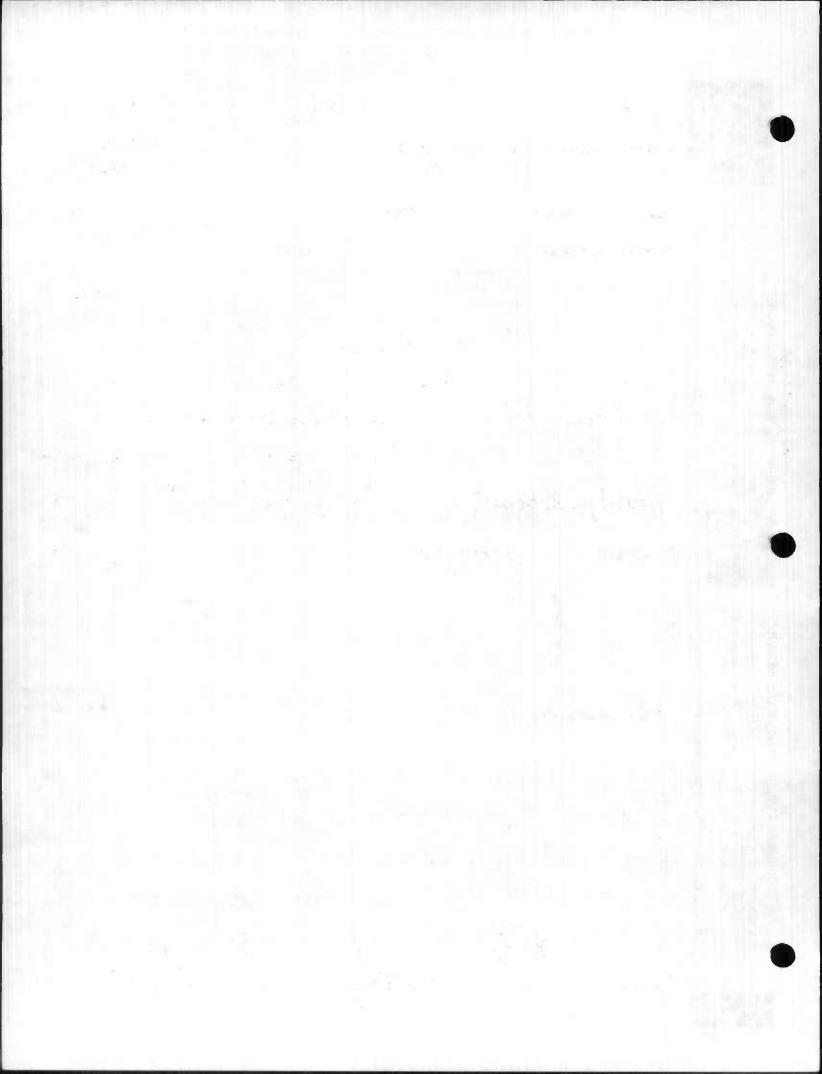
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31. Date filed (Month, Dey, Year)

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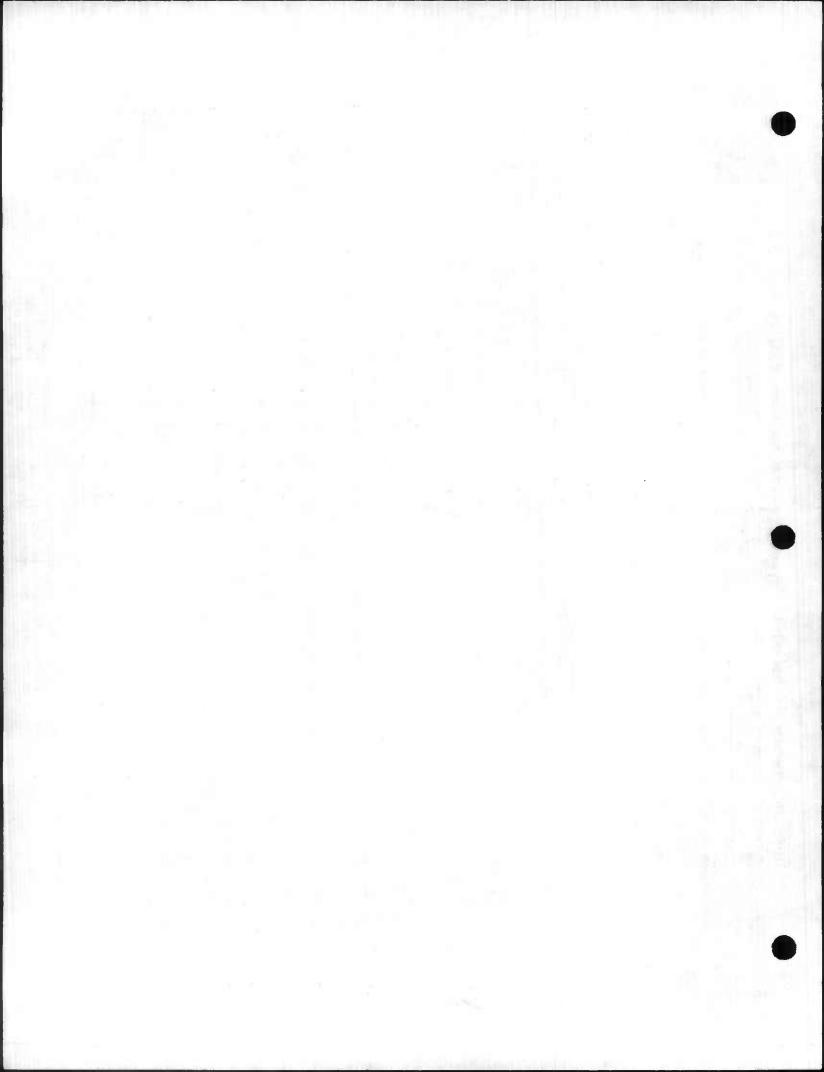
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32. Registraris Signature



State of Maryland / Department of Health and Mental Hygiene 99 1, 26 19

						Cer	tificate of	Death			Reg. No.			
			1. Decedent's Nema (First, Middle, Las	e)						2. Date of De			3. Time of Death	
	Physicia	_	ALICE	J.			HURLEY			Month	Day er 31,1	Year	2:40 PM	A
Š	/Medica		4a Facility Neme (If not institution, give		ar)			4b. City. To		cation of Death	1	y of Death	2.40 FF.	1
A	Examine	er	5249 A, Wigville		.,			Thur				deric	k	
-					Age (in yrs. la:	nd hinth days	If Under 1 Year	If Under		9. Date of Bird				
	Funeral			M 20€F		Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da July 15	y, Year)		place (State or Foreigntry)	n
	Director	-	Usuel Residence of Decedent	7	65					July 13	7,1934	Penns	sylvania	
	pu *	ŀ	10a. Stete 10b. County		10c. City,	Town or Loc	cation					1	Od. Inside City Limits	
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	72 hours after death with the Maryland natural, or term 23a or 28a-1 show dies Examiner must be notified at	<u>e</u>	5249 A, Wigville F	Road			21788				Unite	d Sta	tes	
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Maryland	2 should and Men is marks sumatic	-	19a. Informant's Neme/Reletionship (T	vpe. Print)		19b. Meitin	g Address (Street				-M	. Stete. Zic	Code)	
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Baltimore,	Department Department Important: any Injury o		21. Signature of Funeral-Service Licens	100	1/	22   Si	Nama and Addre	ss of Fecilit	1 Ho	me				
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U	Examiner		resulting In death)	8EV2	Due to for s	/ De a conces	unnon of): /	1 :00	000				5 790,	_
1		ē		11 0	10,01,600	as a coused	uerice orj.	13,5	022	2		15	016	
	De une de la company de la com			b. 17 11	20/ Q	100	our.					t	000	
ď,	executed in and rial-transit	R K	Sequentielly list conditions, if any, leading to immadiete cause. Einer Underlying											
68760,	entificate be executed ding physicien and se as the burial-transit	5	Cause (Diseese or Injury thet initiated events	c. 11/11			e consequence of:					t	040	
88	phy s the		resulting in death) Last		Due to (or a	0 -	. /		0				0	
×	ding se a	ξ		1190	Un.	Reg.	SToric	33	25	nde	049		800	
Bo	- 5 -	18							U			1		
o	es that the death igned by the atte be detached for	28	Part II. Other algnificant conditions co	ntributing to death	but not result	ing in the un	derlying cause giv	ven in Pert I		23b. Did 1	tobacco use c	ontribute to	o the cause of death	7
م			Olympia of	22th	of,	110				1 De	Yes 2 No	3 Prol	bably 4 ☐ Unknow	m
S,		D A	Charle of	700		70	00.					1		_
Record	v requires been sign should be	9	parin	onal-	7 ac	y sea					an eutopsy med?	av	ere autopsy findings ailable prior to	
ec.	lew ras by 2 st	2	,		Reli	rus						of	mpletion of cause death?	
	The I	5	Vendes and	being	14 - 1	62	11.01.0	10.10.0		101	res 2/0 No	10	Yes 2□ No	
ā	sician: The lew certificate has b director, page 2 s		25. Was case referred to medicat	1700	maj		IN OU	26 Place	of Death	(Check only o				
of Vital	Physician: this certific ral director,	0	examiner?	Hospitet:	tient 2 TEI	R/Outpatient	3□ DOA Oth	vor:	ırsing Hon	1.4	dence 8 🗆 Ot	har (Snacil	(v)	
	r this eral d		27. Menner of Death	28a. Dete of In	jury 2	8b. Time of	28c. tnjur				how injury occu		77	-
0	Attending Fir death.  Detor: After by the funerification.	5	Naturel 5 Pending investigation	(Month, E	lay Year)	Injury		rk? Yes 2 □	No					
3	death. ctor: A y the fi	2	3 ☐ Suicida 6 ☐ Could not be	28e. Pieca of t	niury - At hom	e. ferm. stre	et, fectory, office	,	2	28f, Location (S	Street and Num	ber or Run	al Route Number,	
Division	tal or Attanding P rs after death. al Director: After t led in by the funer. Certification:	5	4 ☐ Homicide		etc. (Specify)					City or Tov				
			29a. Certifying Phy	eician: To the hea	t of my knowle	edne dest	nonurrad at the st-	me date an	d place o	and due to the	reuspie) and -	nanner en a	tated	
	ne Hospi n 24 hou he Funer pletely fil	3	(Check only one) 2 Medical Exami	iner: On the basis end menner:	of examination	n and/or inv	estigation, in my o	ppinion, dee	th occurre	ed at the time,	date and place	, and due to	the cause(s)	
	within 7 to the comple		29b. Signature end title of certifier	Tellinelli one			29c. Licens	a number		24	29d. Date sign	ed (Month	Day Year)	_
	C N C S		Social and the of certifier		. 0	0	250. LIUOTIS	Hi	140	57	/	l		
			Donite (1 b)	cour As	el-K	175	all	L I		(	31/04/	200	0	
		1	30. Neme and address of person who co	ompleted cause of	death (Item 2	(Type, F	Print) 5	26	ATTE	ER 37	1			
			DAVITATICRE	WEL-	PRT	IERI	19 T	HUR	ino	NTI	MDE	202	0	
	State		31. Dete filed (Month, Day, Year)	2000 32. Regis	Signal		13. ja	one	1					

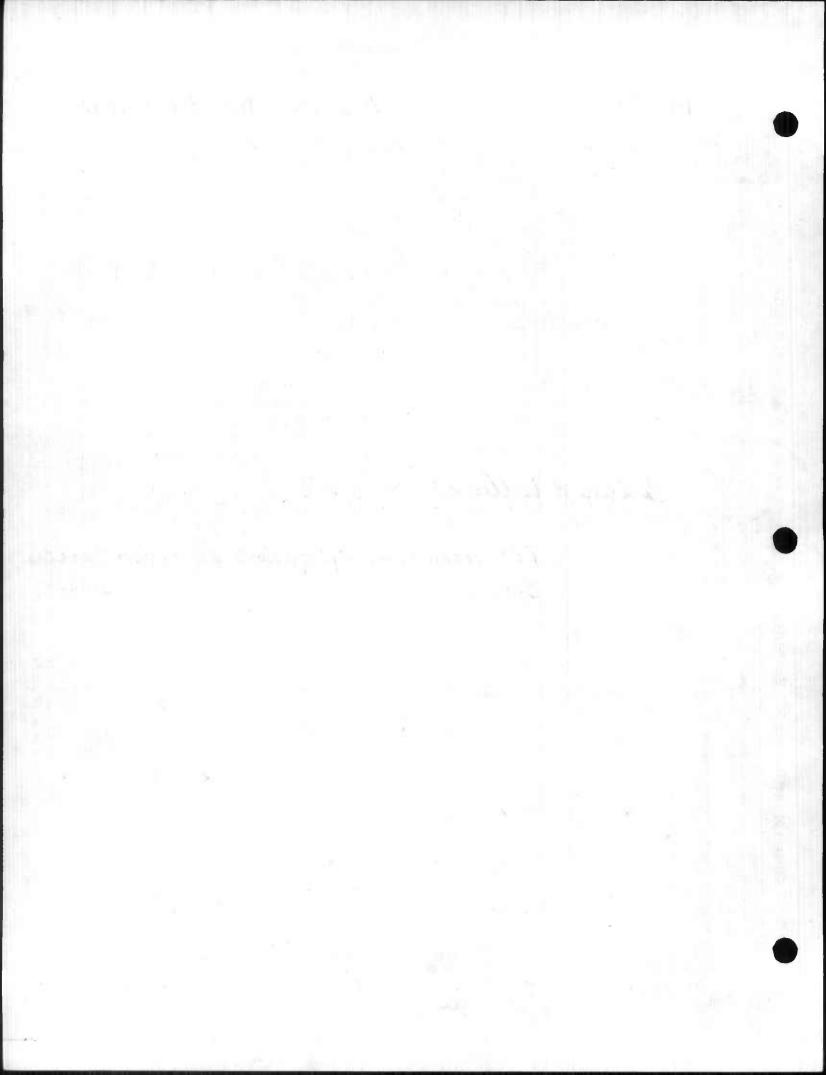


State of Maryland / Department of Health and Mental Hygiene QQ 42620 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 29 120pm 4b. City, Town, or Location of Death /Medical Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner HOPKIN 6. Sex 8. Dete of Birth (Month, Day, Year) THE JOHNS
5. Social Security Number ALTIMORE If Under 24 Hrs. 8. De VS //OSP/17 7. Age (In yrs. last birthday) If Under Months Birthplace (Stete or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🖸 F 67 19 Director 214-36-0904 Nov Brunswick, Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow na 23a or 28a-f shoy must be notified at 1X Yes 2 No Director Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Peach Orchard Lane Funeral 21716 filed within 72 hours after deeth Hems! 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 21215-0020 ŏ 1 ☐ Yes 2XXNo Specify Black Specify: þ 3\\ Widowed 4 \ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. National Geographic Elemantary/Secondery (0-12) College (1-4or 5+) Society i. Peges 1 and 2 should be filed w transt of Health and Mental Hygier tant: If them 27 is marked other th ilury or other traumatic avent, the Senior Analyst Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be William Ernest Onley Lottie Ellen Hardy 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye H. Williams, Daughter 805 Second Avenue, Brunswick, MD 21716 20e. Method of Disposition 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete Department o Important: If any Injury or Fairview Cemetery 1/5/2000 Frederick, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee John T. Willjams Funeral Home 100 Petersville Road, Brunswick, owner iams, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · RECURLENT ACUTE MYFLOGENOUS LEUKEMIA disease or condition resulting in death) Examiner Physician/Medical Examiner the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): The lew requires that the death certificate be exec Box 68760, attending physician Due to (or as a consequence of) for use as signed by the a Part II. Other stantfloant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? pege 2 has 1 Yes 2 □ No 1 Tyes 2 No certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 M Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) uneral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding Investigation 1 Meturel 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident the 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be detarmined 3 ☐ Sulcide Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicida Hospital 29e. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and mannar as stated. complataly 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. (Check only one) 9 29b. Signature and tilling of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 December 31, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Dooley, Tower 110, Doctors Lounge, Johns Hopkins, Baltimore, Mary land 21287

DHMH 16 Rev 6/95

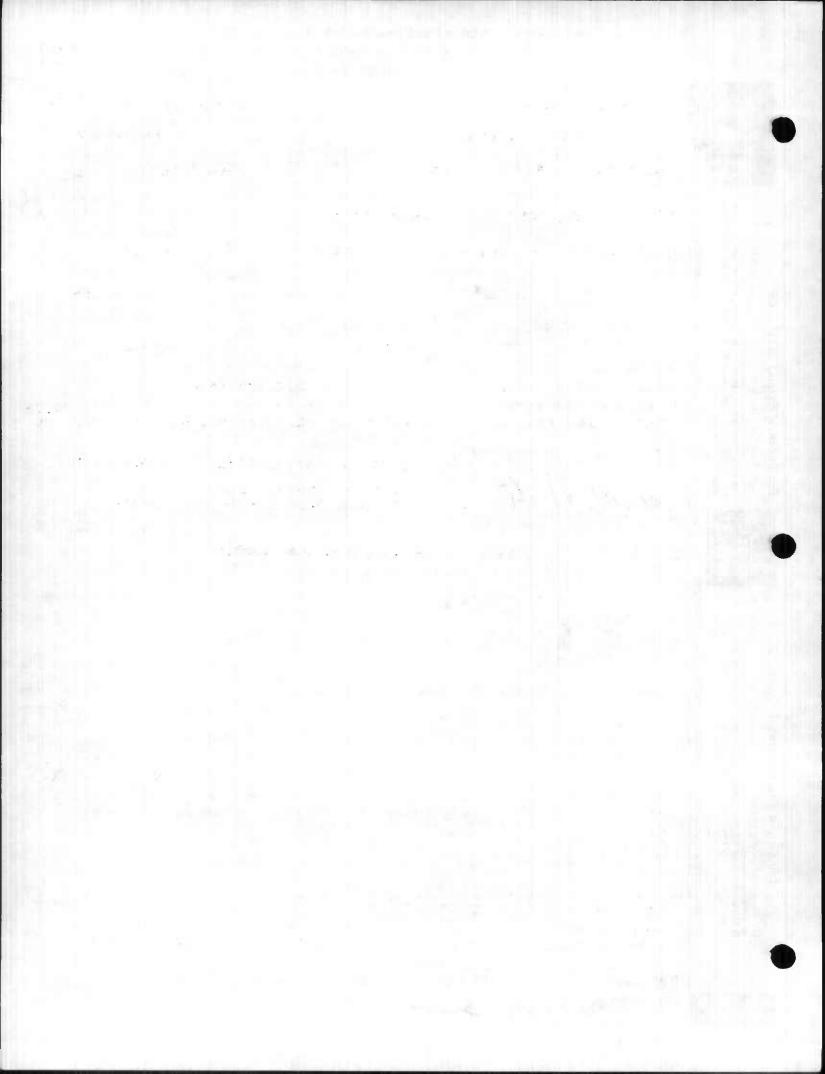
State Registrar 31. Date filed (Month, Dey,

32. Registrary Signature



State of Maryland / Department of Health and Mental Hygiene 99 1, 2621

						Ce	rtificate of	Death			Reg. No.			
	Physician /Medical		ne (First, Middle, L	JINB2						2. Data of De Month	Day	Yasr 1999	3. Time of Death	
	Examiner	4a Facility Nama (If not institution, give street and number)  4b SHTAL							own, or L KVIU	ocation of Deat	montrong			
	Funeral Director	5. Social Security I	-6771	Sex 1139ÎM 2□F	7. Age (In yrs. last to 45		Months Deys		If Under 24 Hrs. Hours Min.		7 1954	9. Birthy Cour	olaca (Stata or Foreign htry)	
	p >	Usuai Residence o	10b. County		100 (	City, Town or L	conting					1.	Od Incide City Limite	
	e Manylar la-f ahov		Montgo	omery	l l		rsburg						0d. Inside City Limits 1 ☐ Yas 2 No	
	r 28	10e. Street and Nu		10f. Zip Code				10g. Citizen of	Whet Cou	ntry?				
	h wil	14251	Quince	Orcha	rd Rd.		2087	8			U.S	. A .		
020	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f ahow solical Expenser must be notified at letted by Funeral Director		11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedant Evar in Uarmed Forces?  1 □ Yes 2 ☑ No If Yes, Give Yaar or Dates:				Was Decedant of if Yas, specify Cul			pecify Yes or No Rican, etc.)	Bia	e - Amarick, White,		
9	hou				Dates.	16a Daoi	dent's Heuri Occu	metion			16b. Kind of B	ueinaee/In	dustry	
5		(Spe	15. Decedent's E cify only highest g	ade completed	)	(Giv	edent's Usuai Occu e kind of work done DO NOT use retin	e during mos	st of work	king	100. Kind of B	uəli idəəvii i	uosity	
1212	d withir	Elementary/Sec	Elementary/Secondary (0-12)				iver				Deli			
Maryland 21215-0020	S la S		17. Fether's Name (First, Middle, Last)  Delton Haines, Sr.					Bas	rbar	a Hah				
ar	d 2 should the and Mer 7 is marke traumatic		leme/Relationship	(Type, Print)		19b. Mai	ing Address (Stree	et and Numb	er or Ru	ral Routa Numb	per, City or Town	State, Zij	Code) 20878	
	rt 27	Wanda	Haines/	spouse	Э	1425	1 Quinc	e Ord	char	d Rd.	Gaith	ersb	urg, MD	
re	of Heal of Heal of them 2 or other	20a. Method of Dis				. Plece of Disp	osition (Name of	acel		Date	20c. Location	City or To	own, Stata	
altimore,	Page nent of ury or	4 Donation	□ Cramation 3 I 5 □ Other (Spec	ify)		sthav				12/31 Frederick, MD				
Bal	permit. Departrimportal Importal any init	21. Signature of Euneral Service Licensee 22. Name and Addrass of Facility Hilton Funeral Home												
_	00560	11/4	MI /-XV	in		R	0x 86	Barne	esvi	110.	MD 201	338		
		23a. Part 1. Enter	the disease, or cor art failure. List only	nplications that	caused the de	ath. Do not er	nter the moda of dy	ing, such as	cardiac	or respiretory	arrest,		Approximate interval Between	
	Physician (Markins)												Onsat and Death	
	/Medical Examiner	immediate Ceuse disease or conditi resulting in death)	on	" HULLED	HOSCUE	ROTTO (	CARDIO UNIS	CUCIMI	- VIS	4136		1		
	Control of the last				Due to	(or as e conse	equence of):					i		
П	nin sit		b											
,00	certificate be executed ding physician and ise as the burial-transit		onditions, mmediate lerlying		Due to (or es a consequence of):									
68760,	sata b shysic the b	ihat initiated event	ts	C	Due to (or as a consequence of):									
XO	_ 63 =			d								-		
m.	death e atten	Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.								23b. Did tobacco use contributs to the cause of dea				
P.0	d by the									1 Yes 2 No 3 Probably 4			bably 4 Unknown	
of Vital Records,	equiras ti										s an autopsy ormed?	av	ere autopsy findings allable prior to empletion of cause	
Rec	has has										Vac alleri	of	déath?	
a											Yes 2 No	1	Yes 21XNo	
5	Physician: this certific ral director.			Hospitei:			_ 0	ther.		th (Check only				
5	His hy			1 1		ER/Outpatie	I AUG IIE	4LIN	ursing H		idence 6 Oth	-	(y)	
ion	After fune	27. Menner of Dee 1 Devatural 2 Accident	5 ☐ Pending Investigatio		of injury nth, Day Year)	28b. Time Injury	W	uryat ork? ⊒Yes 2□	lNo	28d. Describe	how injury occur	rea		
Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 4 Homicide	6 Could not determine	28e. Plac	28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)						(Street and Num own, State)	ber or Rur	al Route Number,	
	Hospi 4 hou 4 hou tely fill icai	29a. Certifier (Check only one)		miner: On the I			th occurred at the investigation, in my							
	To the comple	29b. Signature and	d title of cartifiar	(	OME)			S236			29d. Date signed DECOMBER			
		30. Neme and edd	Iress of person who	completed cau	use of deeth (it	em 23a) (Type	Print)	Rock	viu	E, MO	20852			
	State Registrar	31. Date filed (Mod	-		Registral's Sig		B. A							
	negistiai						1 19	vouk	-/					



Certificate of Death

Henry J. Higgins 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) SHADY GROVE ADVENTIST HOSPITAL

December 22, 1999 6:28 PM 4c. County of Deeth

**Funeral** Director

288-71

b 238

Berns

'natural', or

Hygiene.

12 should be fi h and Mental H Is marked off

Department of Health and Important: If New 27 is ma

**Physician** /Medical

Examiner

physician and s the burial-transit

188

this

To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

þ

Completed

Be

To

Certification:

edical

Box 68760.

Records, P.O.

of Vital

Division

Saltimore, Maryland 21215-0020

Directo

ğ

Be

5 Social Security Number 7. Age (In yrs. last birthday) 10XM 20 F 218-01-2867

ROCKVILLE If Under 24 Hrs. ff Under 1 Year Months Days 8. Dete of Birth (Month, Day, Year) Hours

MONTGOMERY Birthplace (State or Foreign Country)

Usual Residence of Deceden 10a. Stete 10b. Counts

1. Decedent's Neme (First, Middle, Last)

10c City Town or Location

Feb. 03, 1916 Maryland

10d. Inside City Limits

42622

Montgomery Maryland

Rockville

1 ☐ Yes 2 No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

9701 Medical Center Drive 11. Meritel Stetus

20850 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indian, Bleck, White, etc.

1 □ Never Merried 2 □ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII

1 ☐ Yes 2 X No Specify:

White 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative

Food Distribution Co.

17. Father's Neme (First, Middle, Last)

Higgins

Mamie Moxley

18. Mother's Name (First, Middle, Maiden Surname)

Dete

Willard 19e. Informent's Neme/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Judith E. Baker - Attorney

20b. Pleca of Disposition (Neme of cemetery, crematory or other plece)

931-B Russell Avenue, Gaithersburg, Maryland 20879 20c. Location - City or Town, Stete

20e. Method of Disposition

Mount Olivet Cemetery

12/27/99 Frederick, Maryland

1 ₺ Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funerel Service Licensee

22. Nome and Address of Facility Olin L. Molesworth P.A., Funeral Home

locaswort

26401 Ridge Road, Damascus, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line.

20872-011 Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Physician/Medicai

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

MAHAK

1 Yes 20 No 3 Probably 4 Unknown

23b. Did tobacco use contribute to the cause of death?

24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending Investigation

6 Could not be determined

1 Impatient

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Placa of Death (Check only one)

GROVE RD ROCKING, MO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27 Manner of Death

1 Accident

3 ☐ Sulcide

4 Homlcide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

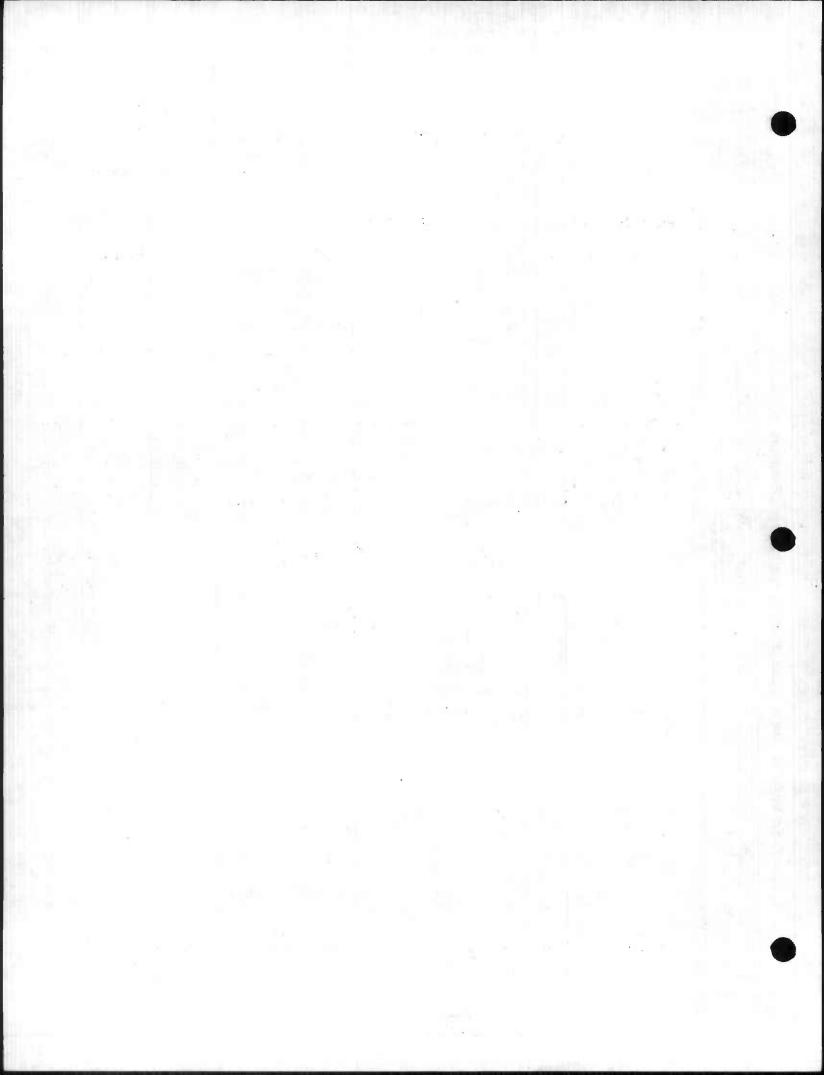
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 (HADY

Hospitel:

CHANACES 31. Date filed (Month, Dex

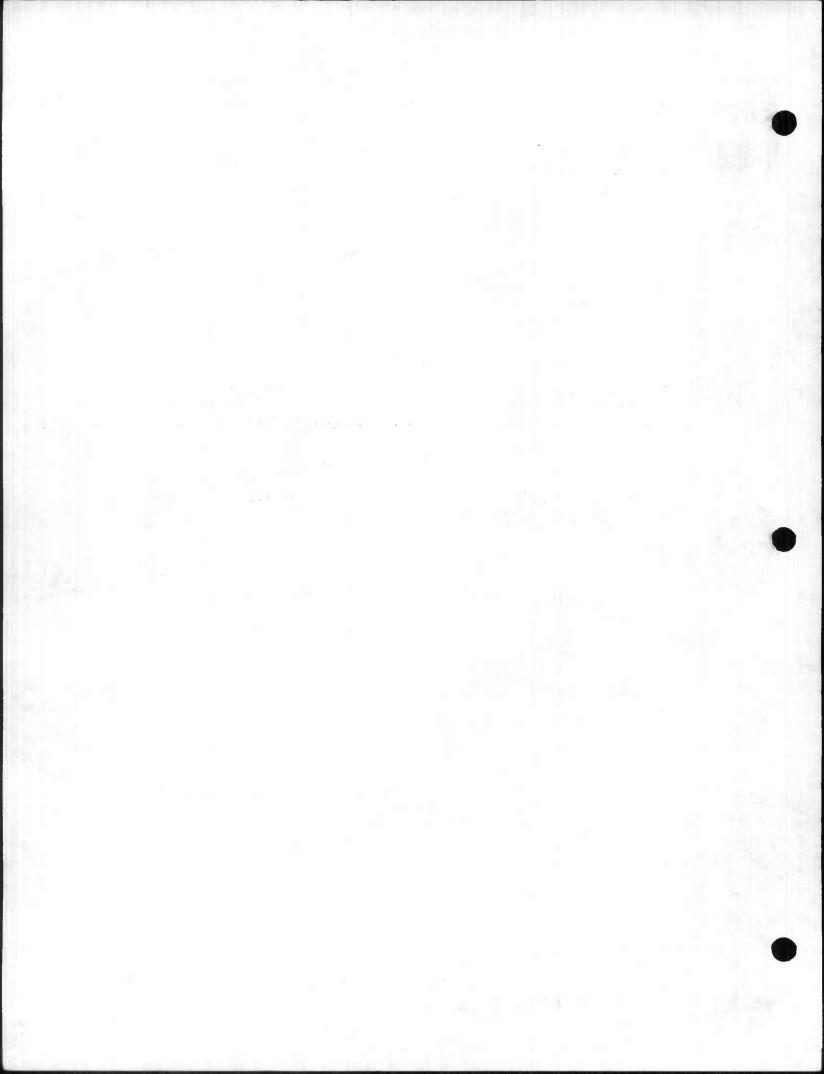
32. Registrer's Signeture 8 1999

State Registrar



			Cel	tificate of	Death		leg. No.		623		
Physician	Decedent's Name (First, Middle, Last	50)	11			2. Date of Dea Month	Day	Year	ima of Death		
/Medical	Joseph OW  4a Facility Name (If not institution, give	ens	Hari	rison	4b. City, Town, or L	Decembe	r 20, 1		:16 PM		
Examiner	Frederick Memori						-	derick			
Funeral	5. Social Security Number 6. S	ex 7. Age (In )	rs. last birthday)	If Under 1 Year	Frederic M Under 24 Hrs.	8. Date of Birth			State or Foreign		
Director	578-20-3508	⊠M 2□F	85 Yrs.	Months Days	Hours Min.	June 28	3, 1914	Washing	gton, DC		
deeth with the Maryland ms 23s or 28s-4 show rmist be notified at neral Director	Usual Residence of Decedent  10e. State 10b. County	10c.	City, Town or Lo	cation				10d. fn	side City Limits		
a or 28a-f show be notified at Director	Maryland Frederi		Yes 2 No								
or 28e-fe be notified Director	10e. Street and Number			10f. Zip Code			log. Citizen of V	Vhat Country?			
23a	14415 Shirley Bo	hn_Road		2177			Inited S	States			
"natural", or items 23a ed cal Example: must leted by Funeral I	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ ∏	1	Vas Decedent of H f Yes, specify Cub i ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - American Inc k, Whita, etc. : White	lian,		
varit, the Maderal	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L	DO NOT use retire	during most of work d)	ring		siness/Industry			
F O	17. Father's Name (First, Middle, Last)	5+	Math	ematicia	18. Mother's Nam	a /Firet Middle		vernmen	t		
marked other umatic event, to To Be Co	Joseph Owens Harr				Bertha		Walter Comen	,			
T T	19a. Informant's Name/Relationship (1		19b. Mailin	g Address (Street	and Number or Rui		r, City or Town,	State, Zip Code	)		
	Frances D. Harris				Bohn Roa	d Mt. A	iry, Ma	ryland	21771		
= 1	20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐	Removal from State	<ul> <li>b. Place of Disportant Cometery, cren</li> </ul>	sition (Name of natory or other pla	ce)	Date Dec. 23	20c. Location -	City or Town, S	tate		
Jury	4 Donation 5 Other (Specify			ve Cemete	ry	1999		y, Mary			
any Injury o	21. Signature of Funeral Service Licen	arta		E. Ridge	eville Bl	tauffer vd., Mt.	Funeral Airy,	Home, Marylan	P.A. d 21771		
sician edical	23a. Part1. Enter the disdase/or comp shock, or heart failure. List only	one cause on each line.		er the mode of dyin	ng, such as cardiac	or respiratory en	est,	Inter	oximate val Between et and Death		
miner	disease or condition resulting in death)		o (or as a conseq	uence of):			_	12	295		
i e		p Parki	NSON'S	Disea	se			M	onths		
e buriel-transit cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c										
5 7	that initiated events resulting in death) Last	Due to	o (or as a consequ	uence of):							
d for	Part If. Other significant conditions co	ontributing to death but not	resulting in the ur	vdertving cause gis	ven in Pert I	23b. Did to	obacco usa co	ntribute to the o	cause of death?		
be detached for use of by Physician/M	Cerebrourse		sease	denying cause git	Total Forti.		'es 2□No		4 Onknown		
should						24a. Was a perfor		available	on of cause		
rector, page 2 Be Comp						1 U Y	es 2DNo	1 🗆 Yes	2016		
D ector	25. Was case referred to medical examiner?	Hoenitat		0.1	26. Place of Dee	th (Check only or	ne)				
To To	1 Yes 2 TATO		28b. Time of		4 LI Nursing H	oma 5 Resid					
completely filled in by the funeral di Medical Certification: To	1 Drietural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	y at rk? Yes 2 □ No	28f. Location (S			ta Numbar		
il Certif	4 Homicide determined	28e. Place of fnjury - A building, etc. (Spo			me date and store	City or Tow	n, State)				
pletaly fil	(Check only 2   Medical Exam	iner: On the besis of axam and manner stated.	ination and/or inv	restigation, in my o	ppinion, deeth occur	red at the time, o	late and place,	and due to the o	ause(s)		
W w	29b. Signature and title of certifier			29c. Licens	se number	4	29d. Dete signe	d (Month, Day, '	Year)		
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DHMH 16 Rev 6/95

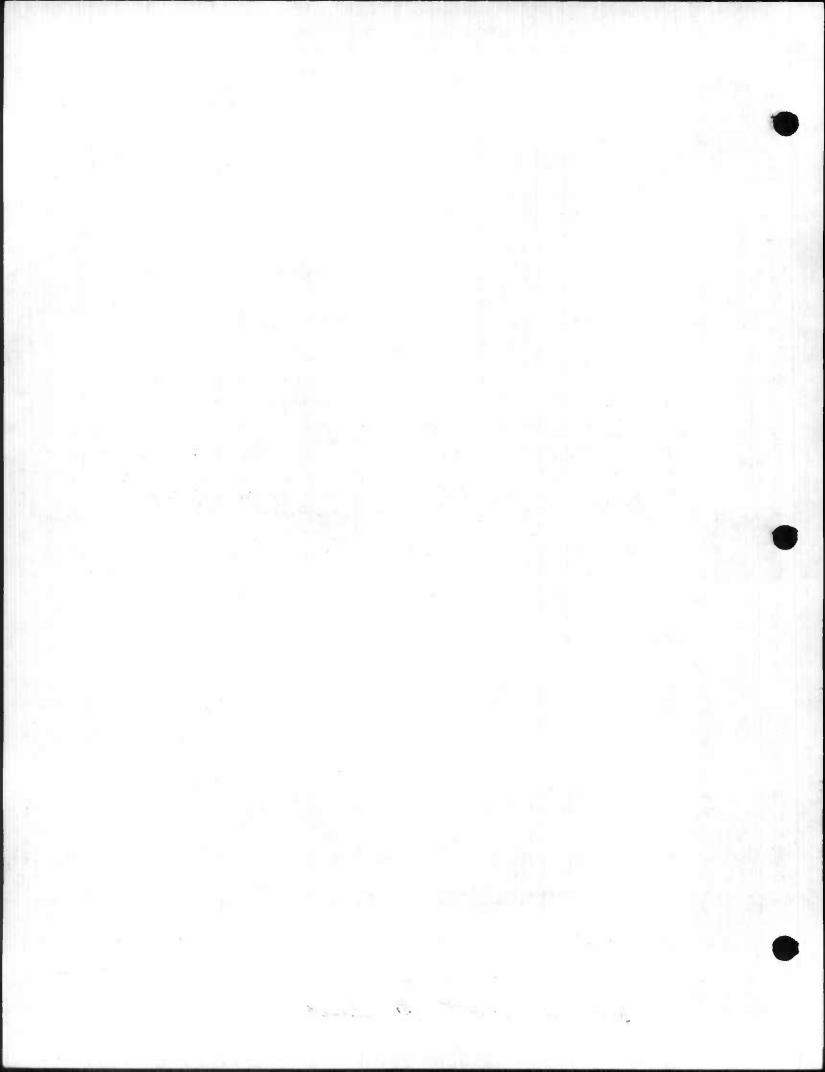


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Marv 17, 1999 11:23 AM 4c. County of Death Hartman December /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
Feb. 23, 1924 Mary Land If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 20 F Days Hours Months Yrs. 75 Director 213-16-1082 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow ahow 1 Yas 2 No Frederick Funeral Director Maryland Ijamsville 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be 10046 Old National Pike 21754 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Fred. Co. School Board . Pages 1 and 2 should be filed vitment of Heelth end Mentel Hygle tant: If Itam 27 is marked other titury or other traumatic event, to Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Roger Delaine Breckenridge Bessie Elizabeth White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Powell (Daughter) 6005 Harley Road, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or page. Mount Olivet Cemetery 12/27/99Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Lice 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Enter the disease, or compt or heart failure. List only or Physician trnmediate Cause (Finat disease or condition resulting in death) /Medical Respiratory Examiner Examiner Sepsi physician and the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Obstruction Bowel Box 68760, Small Physician/Medical Due to (or as a consequence of): for use es Lung Cancer 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown p Division of Vital Records, 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: Al 1 Tyes 2 No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the ceuse(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2, M.D December 18, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick. 201 THI CLOUDE Avenue, D3 Kanan Hudhud, 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State Registrar

**DHMH 16 Rev 6/95** 



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month De Charles Linwood Jenkins 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Min. March 29, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1⊠M 2□F Yrs 220-18-0066 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1K Yes 2 No Marvland Washington Hagerstown 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 21740 109 Devonshire Road USA Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married 1 X Yes 2 No If Yes, Give White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Foreman M. P. Moller Organ 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Charles Albert Jenkins Myrtle Viola Long 19e. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Devonshire Road Wife Hagerstown, Maryland 21740 Anna M. Jenkins 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/4/00 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street 23a Vert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respirefory arrest, Approximate Approximate Approximate intervei Between Onset and Death immediate Cause (Final year disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 768 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of injury (Month, Day Year) 28b. Time of injury 28d. Describe how injury occurred 28c. Injury st Work?

Examiner Physician/Medical å B Š Completed Division of Vital Be edicai Certification: To 84 Altar Director To the Hospital within 24 hours after To the Funeral Dir 華

**Physician** 

/Medical

Examiner

**Funeral** 

Director

'natural', or flams 23a or 28a-f show

Hygiene.

12 should be fi h and Mental H I is marked off

Department of Health as Important: If Nem 27 is any injury or other trau

**Physician** /Medical

Examine

Pages 1 and 2 should

hours after

Baltimore, Maryland 21215-0020

must be notified at

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Funeral

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25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1- Neturai 5 Panding investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner atated. (Check only one)

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29c. License number 29d. Date signed (Month, Day, Year) 02145 2000

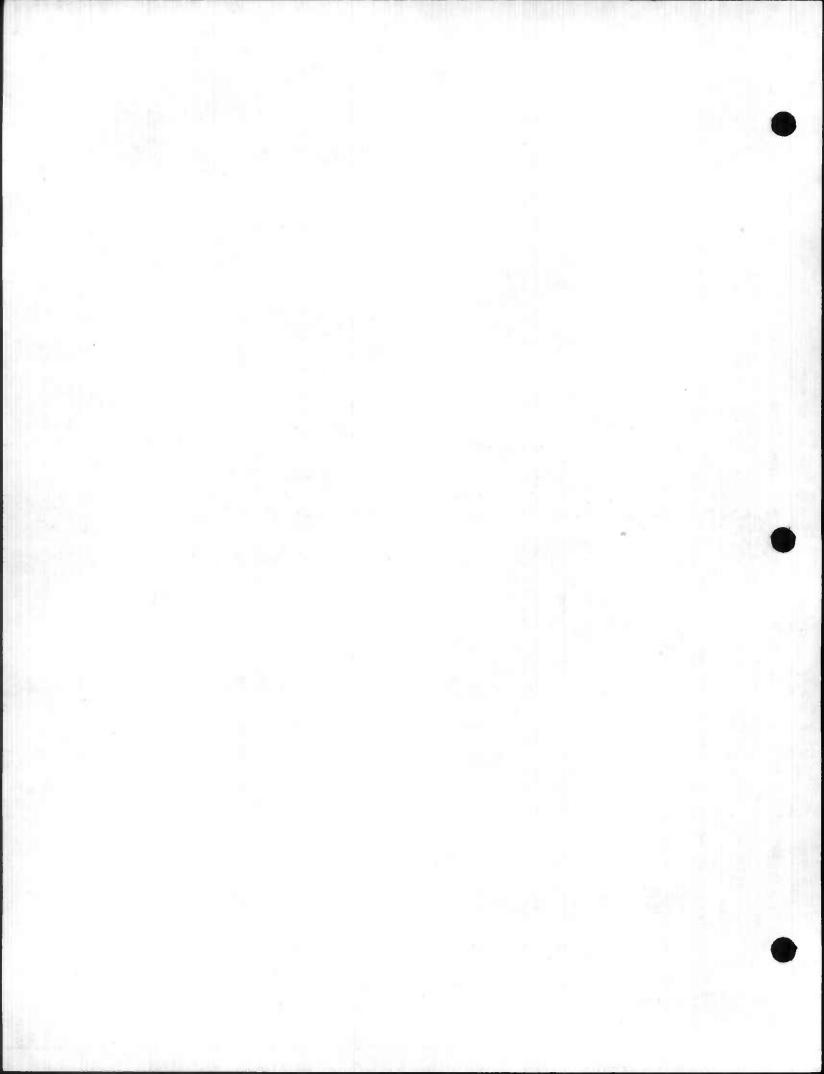
30. Hama and address of person who completed cause of death (item 23a) (Type, Print)

mp-12821-OAKHILL AVE. HAGERSTOWN. MO ABDUL WALTEGO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

**DHMH 16 Rev 6/95** 

29b. Signature and title of certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #11. 12/29/99, BAG, Kent County Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** William Johnson 1:30 December 21,1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Medical System University of Maryland Bultimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F May 26, Director 167-24-5249 1930 Abington, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2No Directo 28e-f Maryland Kent Tolchester / Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 Funeral 21247 Chesapeake Rd 21620 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☑ Yes 2 ☐ No
If Tes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filled within 72 hours after ried 2 Married 6 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 years Electronics Engineer Wilkinson Electronics 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental 7 is marked of traumatic av Clarence W. Johnson Wreatha Sprouse Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) nt of Health a If Nem 27 is or other tra 21247 Chesapeake Rd. Chestertown, Md Harriet Johnson / wife 21620 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Pauls Cemetery 12/28/99 Chestertown 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home Chestertown, 130 Speer Rd. Md ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one ceuse on each line. Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Fine 3 days he map tysis disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner mysses The lew requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical the Due to (or as a consequence of): 980 signed by the at d be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 Yes 20 No

certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be Medical Certification: To

25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Deletural 1 ☐ Yes 2 ☐ No 2 Accident

27. Menner of Death 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certific December 21, 1999 D0052745

MO 30. Name and filldress of person who completed cause of death (Item 23a) (Type, Print) Bultimore, MD Joseph P. Regar 22.5 St. Greene

State Registrar 4 Homicide

31. Date filed (Month, Dey, Year) 32. Registrar's Signeture DEC 23 1999

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42627

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	/Med Exami		4e. Facility Name (If not institution, gi		or)				4b. City, Town, or	Location of Death			-	1.50 1.
1			Hart Heritage Hor	me					Street		Hari	Ford		
П	Funeral	г	5. Sociel Security Number 6.	Sex 7.	Age (In yrs.	lest birthdey		r 1 Year	If Under 24 Hrs	8. Dete of Birth			ace (St	ate or Foreign
	Director		212-01-4622 Usual Residence of Decedent	1( <b>2</b> \$M 2□ F	86	Yrs.	Months	Deys	Hours Min	8. Dete of Birth (Month, Day Mar. 3]	1913	Mary	/lan	d
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	# 15 PO 8	Director	10e. Street and Number				10f. Z	p Code			10g. Citizen of 1	What Count	iry?	
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ore	# Hof H		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremetion 3 [	☐Removal from Stat		iece of Disp emetery, cre			эсө)	Dete	20c. Location -	City or To	wn, Stet	ө
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tu once.		21. Signature of Funeral Service Lica	nsee					ess of Facility	- D 7				
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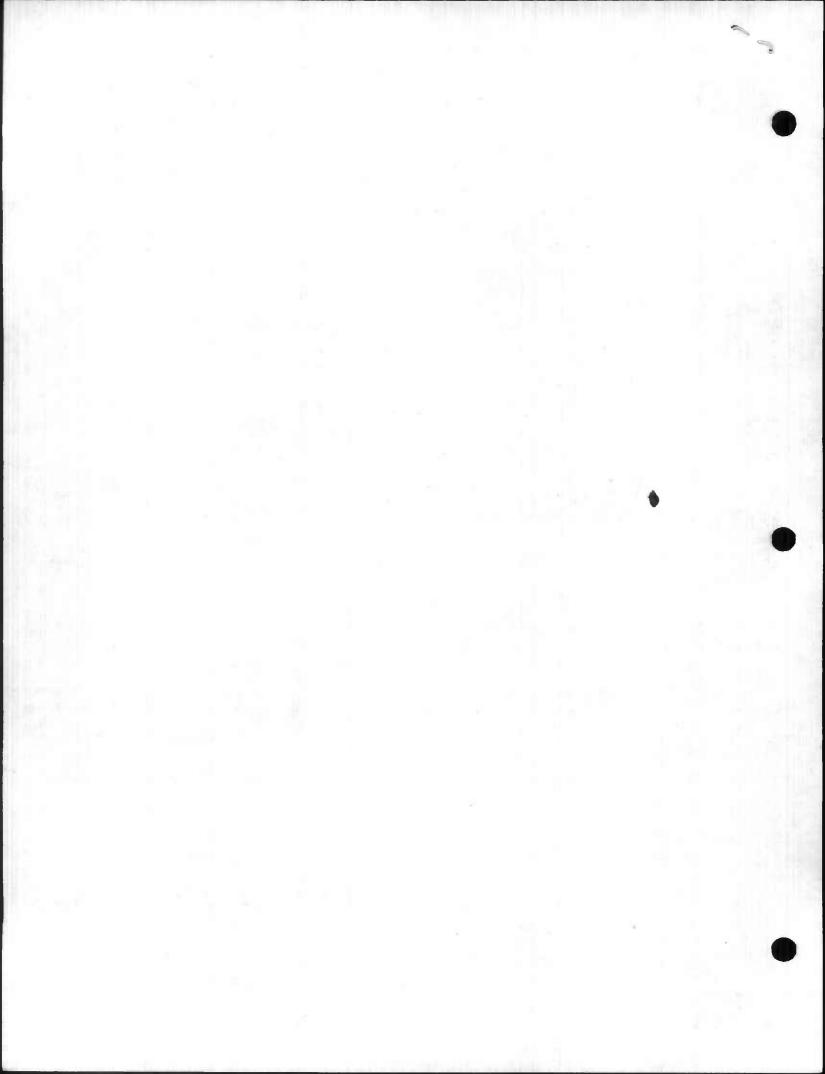
State of Maryland / Department of Health and Mental Hygiene

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020	ar, or her Examiner by Fur	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedan Armed Forces 1 Yes 2 If Yas, Give Yeer or Detes	? ] No		Was Decedent f Yes, specify 1 ☐ Yes 🛣			ecify Yes or No Rican, etc.)		e - Americk, White,	
Maryland 21215-0020	ed within 72 ho ygiene. wer than "natum it, she Medical. Completed	15. Decedent's (Specify only highest g	Education rada complated) College (1-4or +4	5+)	(Give	tent's Usuel O kind of work d DO NOT use n al Worl	one during mo etired)	ost of worki	ing	16b. Kind of B Well		Dept.
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P. O.	that the ded by the detached	Part II. Other significant conditions Pacemake	contributing to death			OSH	e given in Per	tules		tobacco use co Yes 2,21No	ntribute t	to the cause of death
Records,	been sign should be									an autopsy ormed?	av cc	/are autopsy findings valiable prior to ompletion of cause death?
Re	The law ate has page 2								10	Yes 2PINo		☐Yes 2☐No
Vita	iclan: The certificate rector, pag	25. Wes case refarred to medical					26. Pla	ce of Death	Check only			
01 <	5 6 6 F	axeminer?	Hospital:	tiant 2	ER/Outpatier	t 3 DOA	Other: 4	Nursing Ho	ma 5□ Resi	dence 6 Ott	er (Speci	fy)
	Attending Ph r death. octor: After th by the funeral	27. Mennar of Death  1. Natural 5 Pending 2 Accident investigeti		ay Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2		28d. Describe	how injury occur	red	
Division	Patra i	3 ☐ Suicide 6 ☐ Could not detarmine	A ZOB. PIECE OF II	njury - At ho etc. (Specify	ma, farm, str	eet, factory, of	fice		28f. Location ( City or To		ber or Rur	al Route Number,
	Hospi 24 hou Funer Plehy fill dical		Physician: To the besideniner: On the basis and menner s	of exeminet								
	within To the comple	29b. Signature and title of certifier	101	/	14		cense numbe			29d. Date signe	d (Month,	Day, Year)

State Registrar

DHMH 16 Rev 6/95

300 w 9th St Frederick MD



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ

	State of Maryland	d / Department of Health and Certificate of Death	Mental Hygiene 99 42629
Physician /Medical	1. Decedent's Nama (First, Middla, Last)  George May 10 n  4a Facility Nama (If not institution, give street and number)	Kammerer 1 db. City, Iown, or	2. Deta of Death Month Day Year 1900
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I. 215-24-6949 1 ₹ № 2□ F 71	edical system BA!	FIMORE BALLMORE  8. Data of Birth  9. Birtholace (State or Foreign
vith the Meryland or 28e-f show be notified at Director	Maryland Harford	Aberdeen	10d. Inside City Limits 1 □ Yes 2 □ No
ter death v	10e. Street and Number  4411 Philadelphia Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.; Armed Forces?  1 XYas 2 No 194  If Yes, Give	If Yas, specify Cuban, Mexican, Puer	DISA Specify Yas or No- to Rican, atc.)  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, Whita, atc.  Specify: White
2121 ed within railene. or then .	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Giva kind of work dona during most of wo lifa. DO NOT use retired)  Animal Caretaker	U.S. Government
should be fill and Mental H marked out umatic even	17. Father's Name (First, Middla, Last) Walter Norman Kammerer  19a. Informant's Name/Relationship (Type, Print)	Ceceli	ma (First, Middle, Maiden Surnama)  .a Jeanette Weaver  ural Routa Number, City or Town, Stata, Zip Code)
OTO, ges 1 and if hear 2 or other	1 Rurial 2 Compation 2 Parameter State	220 Craightown Road, lace of Disposition (Nama of ematary, crematory or other place) L Air Memorial Gardens	Date 20c. Location - City or Town, Steta
Baltim permit. Pa Department important: eny injury.	21. Significance of Funeral Service Licensee  23a. Pert1. Enter the destination or complications that caused the death shock, or heart tallum, List only one cause on each line.	22. Nama and Address of Facility	. D. 7
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	is	
Box 68760, 72/ each cardificate be executed ettending physicien and for use as the burisi-transit clan/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	r as a consequence of):	
P.O. that the detable detable detable	Part It. Other algorificant conditions contributing to death but not resu	ilting in the underlying cause given in Part t.	23b. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
The law requires the law requires the last been signed page 2 should be d			24a. Was an autopsy performed?  24b. Ware autopsy tindings available prior to completion of cause of death?  10 Yes 2 No
Of Vital I Physicien: The this certificate rai director, page rai director, page rai Co Be Co	25. Was casa refarred to medical axaminer?  1 Yes 2 No Hospital: 1 Thippatient 2	Other	ath (Check only one)  Home 5 Rasidence 6 Other (Specify)
Attending or death.  ector: After by the tune	27. Manner et Death 1 Natural 5 Pending (Month, Day Year) 2 Accident invastigation 3 Suicide 4 Homicide determined 28a. Data of Injury (Month, Day Year) 28a. Data of Injury (Month, Day Year) 28b. Place of Injury - At hobuilding, etc. (Specify	28b. Time of Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No  ma, larm, street, lactory, office )	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospi 24 hour Funer stely fill	and manner stated.	ion and/or investigation, in my opinion, death occ	urred at the time, date and place, and due to the cause(s)
To the compile	29b. Signature and title of certifier.  30. Name and address of person who completed cause of death (Item	29c. License number P 1195	29d. Data signed (Month, Day, Yylar)
State	31. Data filed (Month, Day, Year)  32. Registrar's Signat	225. Green 54	. Balt. MSL.

1/03/2000 Robertson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry Ralph Kersey Jr. December 27,1999 7:10 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 21 1957 Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country) Frederick MD 5. Social Security Number 6. Sex 218-64-2942 XXM 2 F Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Brunswick Frederick YXYes 2 No 10f. Zip Code 10g. Citizen of What Country? 412 East "E" Street USA 21716 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, atc. 1 Yes 2XXNo If Yas, Give Year or Dates; 1 Never Merried 2 Married 1 Yes 20XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Chessie Systems Elementary/Secondary (0-12) College (1-4or 5+) CSX Baltimore Yardmaster 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Susie Delores Powers Harry Ralph Kersey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 East "E" Street, Brunswick, MD 21716 Melinda Kay Barnhouse, Sister 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete XXBurial 2 ☐ Cremetion 3 ☐ Removel from State Resthaven Memorial Gardens 12/30 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Obstructive preumona month mois-5mall Cell Classificina of the lung Due to (or as a consequence of)

**Physician** /Medical Examiner

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Box (

P.O.

Records.

Division of Vital

Physician/Medical Examiner

Be Completed by

To

Certification:

Medical

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

10a. State

10e. Street and Number

**Funeral** 

Director

Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mentai Hyglene. Important: if them 27 is marked other than "naturel", or then any injury or other treumetic event, tre Medical Example page.

Baltimore, Maryland 21215-0020

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Immediata Cause (Finel disease or condition resulting in death)

that initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4/0 Head injune, tracheostomy, left preumothorex

Hypertension, Ahemia, Hypophosphatemia 26. Place of Death (Check only one)

25. Was case referred to medical axaminer? 1 Yes 20 No

5 Pending investigation

27. Manner of Death 2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

28d. Describe how injury occurred

24a. Was an autopsy performed?

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number **D** 47/69

29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Wera autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

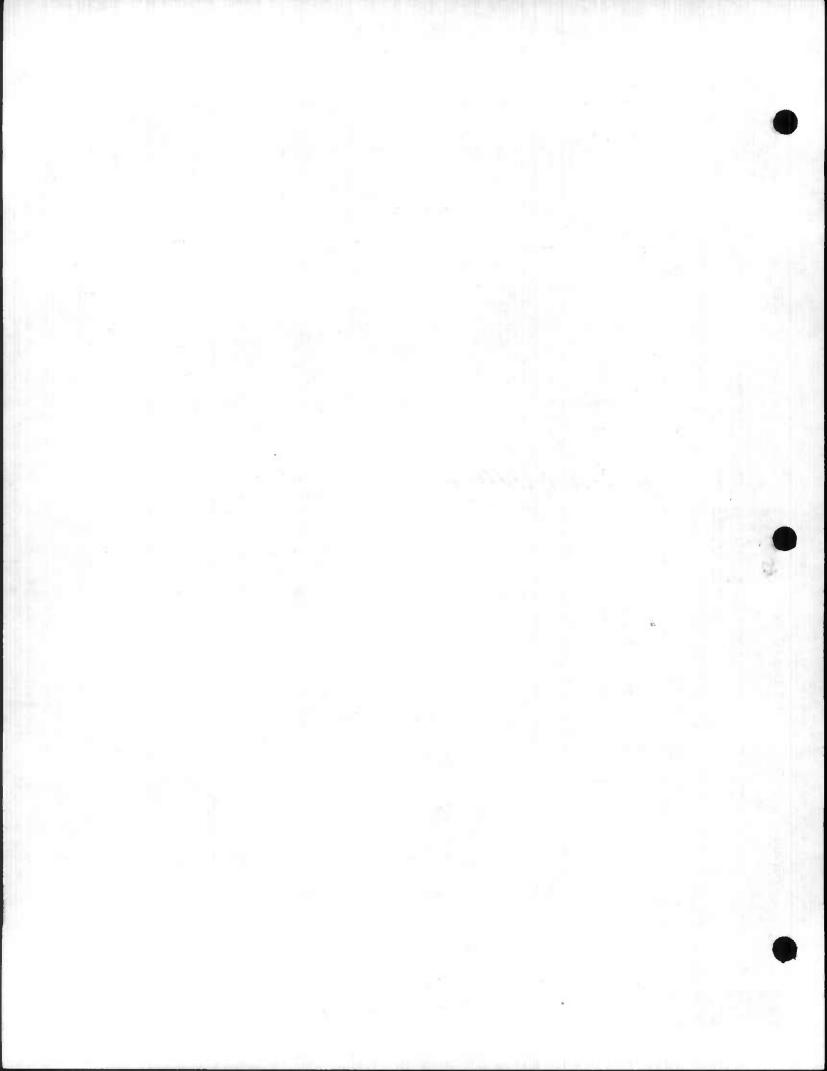
Chan-Hing Ma Ho, MD 610 Ninth Avenue Brunswick Maryland 21716

State Registrar

31. Data filed (Month, Day Yash 3 0 1999 Pegistrant Signature

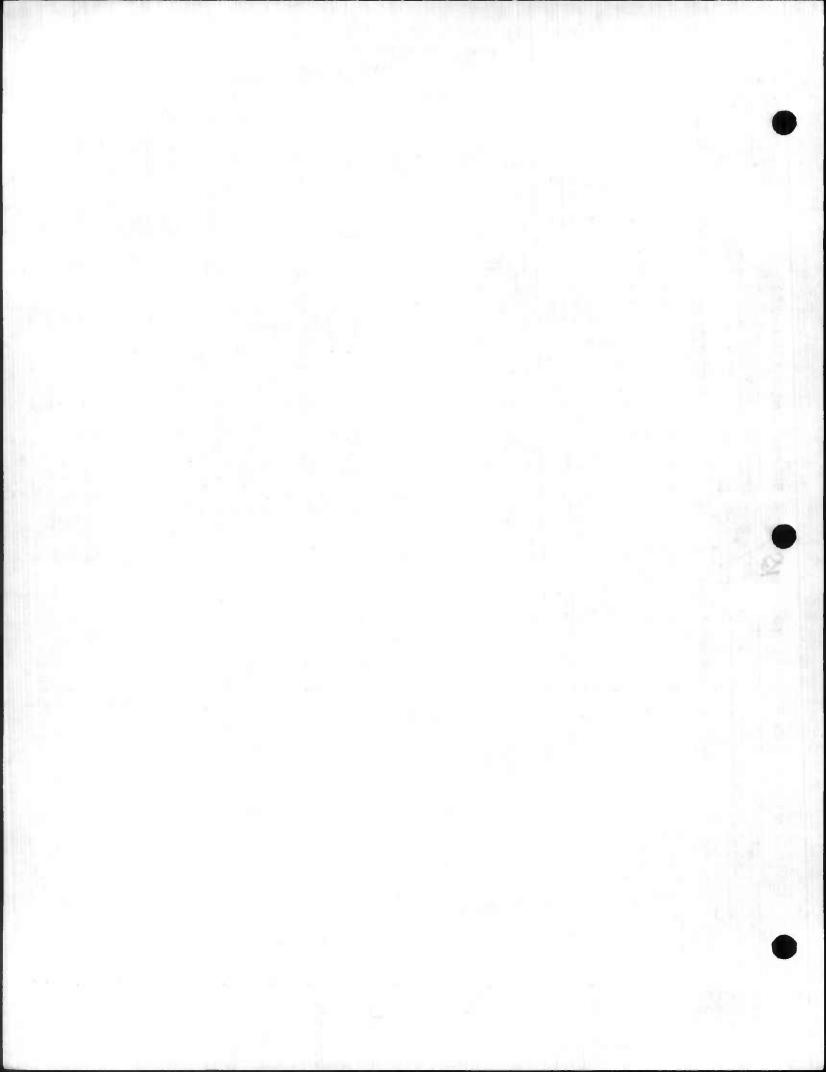
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral



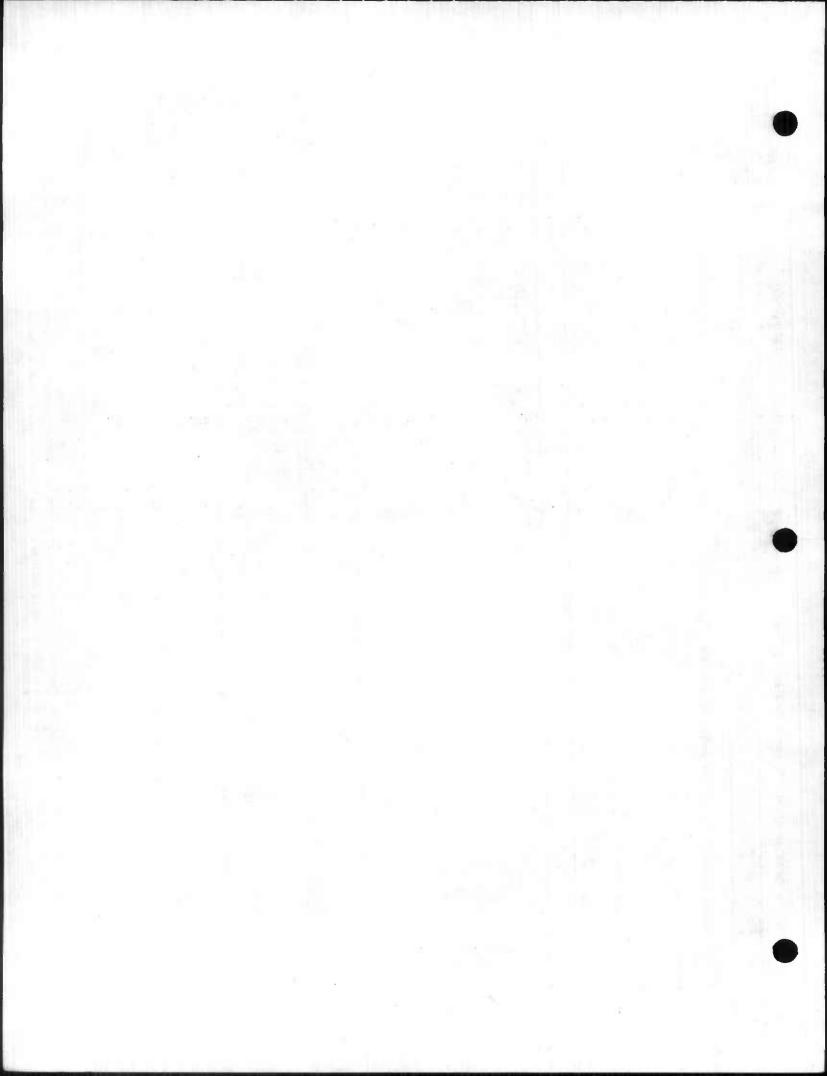
State of Maryland / Department of Health and Mental Hygiene 99 42631

Physician   Conceived   Conc				C	ertificate	e of i	Death		R	eg. No.	-	200	)
Maje		1. Decedent's Neme (First, Middle, La	st)								Vanz	3. Tima o	f Deeth
Examination of Freithy Harmonian (Freithy Harmonian		Walter William	King						_			9:15	A.M.
Social Security Number   Color   15M   20 F   7 Age (p.p.) p. sas principally   15 block   15M   20 F   91 m. security   15M   20 F   91 m. security   15M   20 F   20 F   15M   20 F   2		4a Facility Name (If not Institution, giv	e street and number)			4	b. City, Tov	wn, or Loc	ation of Death	4c. County	of Death		
The state of the s		8820 Dr. Perry	Road							Fred	leric	k	
Director 21/1-10-91/6 December 100, Sales 100, County 100, Sales 100, Sales 100, County 100, Sales 100, Sales 100, County 100, Sales	Funeral				//			Min.	(Month, Day,	Year)	9. Birthp	olace (Stete	or Foreign
The State   100. County   100. Clay, Town or Location   100 Fee Code   100 Fee Fee Code   100 Fee Fee Fee Fee Fee Fee Fee Fee Fee F	Director	217-10-9176	201	91 Yrs.					ec. 3,	1908	Mary	land	
8820 Dr. Perry Road  20842  United States  10 West Decederin Uses of Place Chipmin (Stock) Yes on No. 11 Martial Status  11 West Decederin of Place Chipmin (Stock) Yes on No. 11 Martial Status  12 West Decederin Uses of Place Chipmin (Stock) Yes on No. 11 Martial Status  13 West Decederin of Place Chipmin (Stock) Yes on No. 11 Martial Status  14 West Decederin Status of Place Chipmin (Stock) Yes on No. 11 Martial Status  15 Status of Place Chipmin (Stock) Yes on No. 11 Martial Status  16 Status of Place Chipmin (Stock) Yes on No. 11 Martial Status  17 Fether's Name (First Models, Martial Yes)  18 Status of Place Chipmin (Stock) Yes on No. 11 Martial Status  19 James Albert King  19 James Albert King  10 James Albert	9		100	City. Town or	Location						1	Orl Inside C	lity I imits
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College (1-40 S +)   Store owner/operator   Dry Cleaner   Dry Clean	ar, or he Examiner		1 ☐ Yes 2 ☑ No If Yes, Give					, Puerto f	Rican, etc.)				
College (1-40 S +)   Store owner/operator   Dry Cleaner   Dry Clean	12 ho	15. Decedent's Ed	ducation	16a. Dec	edent's Usua	l Occup	ation	al warkin		16b. Kind of B	usiness/Inc	dustry	
7. Father's Name (First, Middles, Last)  James Albert King  Rosa May Droneburg  Rosa M	up de			life	. DO NOT us	e retired	n)	OF WORKE	,				
20. Method of Disposition (State   Dock of Control   Dock of Contr	Con the	8		Stor	e owner	r/op						r	
20. Method of Disposition (State   Dock of Control   Dock of Contr	Be subtil	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, I	Aaiden Sumen	ne)		
20. Method of Disposition (State   Dock of Control   Dock of Contr	Men Men To	James Albert King					Ros	a Ma	y Drone	burg			
20. Method of Disposition (State   Dock of Control   Dock of Contr	2 sh and and and and and	19a. Informant's Name/Reletionship (	Type, Print)									Code)	
Separation   Sep	and m 27 her tr		lä.				Road	, Di					2
1.6.21 Opossumtown Pike Frederick, Maryland 21702   23a Pratt Fine the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.	ages not a series	1 ☑ Burial 2 ☐ Cremetion 3 ☐	Removel from State	cemetery, ca	remetory or ot	ther place		D	ec. 28				
1.6.21 Opossumtown Pike Frederick, Maryland 21702   23a Pratt Fine the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.	of the state of th								1999	Frederi	lck,	Maryla	and
Physician (Medical Examiner)    Find a consequence of the condition resulting in death)   Due to (or as a consequence of):	Depart Impo	£2081	t					St					
Physician (Medical Examiner)    Find a consequence of the condition resulting in death)   Due to (or as a consequence of):		23a. Part1. Enter the disease, or com shock, or heart feilura. List only	plications that caused the									Approxima	to
Due to (or as a consequence of):    Due to (or as a consequence of):											- 1	Onset and	Death
Due to (or as a consequence of):    Due to (or as a consequence of):		Immediate Cause (Finel disease or condition	Ayler	ioscle	other	Car	Pin W	4661	an Di	30 NO		necas	10.0
Described to the cause of death of the cause		resulting in death)				-	0 00	000		200			40
Described to the cause of death of the cause	2 2												
Described to the cause of death of the cause	and trans	Sequentially list conditions,	Due Due	to (or as a cons	equence of):						1		
Described to the cause of death of the cause	ficate be any physician as the burlah edical E	cause. Enter Underlying Cause (Disease or injury	c										
Described to the cause of death of the cause	dica dica	that initieted events	Due	to (or as a cons	equence of):	-					1		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    230. Did toolscoe use contribute to the cause of death   1   2   2   No   3   Probably   4   Unknow   2   4   2   No   2   N	E E S		d										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    230. Did toolscoe use contribute to the cause of death   1   2   2   No   3   Probably   4   Unknow   2   4   2   No   2   N	attending for use												
1   Yes   2   No   1   Yes   2   No	ysic y	Part II. Other algnificant conditions of	ontributing to death but no	t resulting in the	underlying ca	ause giv	en in Pert I.				ntribute to	o the cause	of death?
1   Yes   2   No   1   Yes   2   No	hat the de od by the detached	multiple o	CNA 's						100.Y	es 2 No	3 Pro	bably 4	] Unknow
1   Yes   2   No   1   Yes   2   No	signe to d be d be	1							24n Was a	n autoney	24h W	ere autonsv	findings
1   Yes   2   No   1   Yes   2   No	requ shoul										av co	ailable prior empletion of	to
25. Was case referred to medical examiner:    25. Wes case referred to medical examiner:   26. Place of Death (Check only one)	2 20 0										of	death?	
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	t sag .								1 🗆 Ye	s 208No	1[	☐Yas 2□	] No
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	cian ector	examiner?	Hospital			Oth	an.						
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	hysical direction		1 L Inpatient			^	4 🗆 140					(y)	
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	Ing P	1 Natural 5 ☐ Pending		28b. Time Injury					8d. Describe ho	w injury occur	red		
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	tor: the	3 Suicide 6 Could not be		4.5			Yes 201		19f Loantion (Ct	root and Ahuml	has as Dun	al Pauda Alue	mhar
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	or Attending Physician: The law require the death.  Director: After this certificate has been sit in by the funeral director, page 2 should it extilication: To Be Completed I				street, rectory,	, Office			City or Town	n, Stete)	oor or nun	ai riodio riui	noor,
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	pottal filled	29a, Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, de	ath occurred e	et the tin	ne, date and	d place. a	nd due to the co	ause(s) and m	anner as s	stated.	- 1 - 5
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	Fundice Ho	(Check only 2 Medical Exam	niner: On the basis of exar	minetion end/or	investigation,	in my o	pinion, deet	th occurre	d et the time, d	ete end place,	and due to	o the ceuse(	s)
30. Name and extress of person who completed cause of death (Item 23a) (Type, Print)  John A. Switta M.D. 15 E Frederick St., Po Box 30, Williams ville, Md 21743	Withir Samp	29b. Signature and title of corplier			29c.	Licens	e number		2	9d. Date signe	d (Month,	Day, Year)	
30. Name and extress of person who completed cause of death (Nem 23a) (Type, Print)  John A. Swtta M.D. 15 E Frehande St., Po Box 30, Wallers ville, Md 21793		Johnsollti	the am		1	030	020	7		12/28	199		
John A. Swita M.D. 15 E Frederick St, Po Box 30, Waller Eville, Md 21793		30. Name and and rest of person who	completed cause of death	(Item 23a) (Tvn	e Print)						1		
21 Data filed (Month Day Voor) 22 Projectords Signature			4.D. 15E	Evalore	84. St	Po	Box	30	Wallege	sville	Mi	2 21	292
	State							/	- V IV (10-V		1 . 0	001	



State of Maryland / Department of Health and Mental Hygiene 99 42632

		(	Certifica	ite of	Death		Reg	. No.		200	S.ua
1. Decedent's Name (First, Middle, I	ast)						2. Date of Death Month	Dour	Voor	3. Tima of	Death
an Mi	chael Dary	1 Kov	acs				December 1	21,19	999	2:15	AM
4a Facility Name (If not institution, g	ive street and number)				4b. City, Tov		ation of Death	4c. County of			
Frederick Memo	rial Hospita	a1			Frede	rick		Fre	derio	ck	
Social Security Number 6.	Sex 7. Age (	In yrs. last birtho	Month	er 1 Year s Devs		Min.	8. Date of Birth (Month, Day, Y	'ear)	9. Birthpl	ace (State or	Foreign
283-36-8060	TUS MASI	58 Yr	8.			]	Feb. 21,			*	
Usual Residence of Decedent  10s. State 10b. County	11	0c. City, Town o	r Location						10	od. Inside Cit	y Limite
									,	1 Yes	
WV Berkel	ey	Fall:	ing Wa				100	ON: 4141			
10e. Street and Number			101. 4	ip Code			100	. Citizen of W		try?	
1602 North Road				254			W 14 A4		S.A.		
11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Wes Dec	pecify Cut	Hispanic Orig pan, Mexican,	Puerto R	city Yes or No- lican, etc.)		- America k, White, e		
1 Never Married 2 Married 3 Widowed 4 Divorced	1 (XYes 2 □ No If Yes, Give Year or Dates: 1	067 11/	10 Yes	2 \ No	Specify:			Specify:		777	
15. Decedent's		160 0	ecedent's Us	nuel Occu	nation		16	b. Kind of Bu	einose/Ind	White	3
(Specify only highest g	rade completed)	10	Give kind of v	vork done	during most	of workin	9	o. Kind of Do.	311100371110	ostry	
Elementary/Secondary (0-12)	College (1-4or 5+)			ginee				Vitro	Lab	s	
17. Father's Name (First, Middle, La.	st)					r's Name	(First, Middle, Ma	iden Sumame	e)		
Michael Daryl Ko	vacs. Sr.				Pau	lina	Jaros				
19a. Informant's Neme/Relationship		19b. N	Aailing Addre	ss (Stree		_	Route Number, (	City or Town.	State, Zio	Code)	
	Wife)						y Waters	-			
20a. Method of Disposition		20b Place of D	isposition /A	lame of				c. Location - (		wn, Stete	
1 ☐ Burial 2 ☐ Cremetion 3			crematory o			110	122/00	0 1.1 1		37	1 . 1
4 □ Donation 5 □ Other (Spec		Smithsh					2/22/99	Smiths	burg,	Mary.	Land
21. Signature of Buneral Service Lio	angel		22. Neme	end Addr TF	ess of Facility	V & C	SON FUNE	RAT HO	MES	DΛ	
1/4/1/5	XIII	7					FRED				
23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused th	e death. Do no	enter the m	ode of dy	ing, such es o	cerdiac or	respiratory arres	t,	1	Approximate Interval Bety	yeen
aroon, or route lawing. List on										Onset and D	
Immediate Cause (Final disease or condition	a. MULT	794	M	YEL	OMA	L	Igh	†	3	YEX	tres
resulting in death)	a. Du	e to (or as a co	nsequence o	f):		1	()				
Sequentially list conditions,	Du Du	e to (or es a co	nsequence o	f):					İ		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									I		
Cause (Disease or injury that initiated events resulting in death) Last	C. Du	e to (or as e cor	sequence o	f):							
Cause (Disease or injury that initiated events resulting in death) Last											
	d		_								
Part II. Other significant conditions	contributing to death but r	not resulting in t	ne underlying	cause g	iven in Pert I.		23b. Did tobe	acco use con	tributa to	the causa o	f death?
		-					1 ☐ Yee	2000	3 Prob	oably 4	Unknown
							24a. Wes an		24b. We	ere autopsy f	ndings
							performe	ou r	00/	mpletion of c	luse
							1 ☐ Yes	2000		Yes 20	40
25 Was care referred to medical					00 01	-f Death		2940	,,,	1185 24	
25. Was case referred to medical axaminer?	Hospital:	00.00	-4:4 00	004 0	thor		(Check only one)		/0a'4	d	
1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outp	_	DUA	4 LI NUI	-	e 5 Residen			()	
PSNetural 5 ☐ Pending	(Month, Day Y	'ear) Inju		28c. Inju	ork? ]Yes 2∐1			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
3 Suicide 6 Could not	be on Olean Main	- At home form					81. Location (Stre	et and Numbi	er or Rura	l Route Num	ber.
4 ☐ Homicide determine	building, etc. (		i, street, rect	ory, ornoe			City or Town,		0, 0, 1,0,0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
200 Codifies	handalan T- 0 1	and back to t	le others	nd a 2 40	i	d alc =:	and along to the co	- 1 1		olod	
(Check only 2 Medical Ex	hysician: To the best of n aminer: On the basis of ex	amination and/o									,
20h Signatura and filia of cartifier	and manner stete	J.	1	On Lines	se number		204	d. Date signed	1 /Month	Day Veer	
29b. Signature and fittle of certifier	1000 1	LMA		A. LIDER	717	61	290	12./2	1 0	O <sub>1</sub> , 1081)	
Duon.	1 course	- Joseph		N	7, /		4	142	1/1	/	
	completed cause of deal	-		00.	CAM	000	Con	replace		00 71	701
ISNIAN M. O'	CONNOR M	0 50	$\omega$ ,	SEV	HIVE	5.	, rice	3940	- 14	10 21	101
31. Date filed (Month-Day, Year)	QQQ 32. Registrar's	Signature	19	/							
DE C Z Z 1	MAN DEP		43.	Ana	11						



										Death		ental Hygi Re	g. No.		0 0 0
ı	Physic /Medi		1. Dacedant's Nar EMMA	,	Last) DE LITTO	N						2. Data of Death Month DECEMBER		1999	3. Tima of Death 4:00 PM
	Examl				giva street and numi					4b. City, To		ation of Death		nty of Death	
	Funeral Director		5. Social Sacurity 220-92-4 Usual Rasidance	735	6. Sax 7	74 Aga (In yrs. I	last birthday) Yrs.	If Undar Months	1 Yaar Days		Min. M.	8. Data of Birth	925		placa (Stata or Foraign ntry) LAND
	with the Maryland a or 28a-f show be notified at	tor	10a. State	10b. County  GARRI	ETT		, Town or Lo	cation							10d. Insida City Limits X□ Yas 2□ No
	with the	Directo	10e. Straat and No					10f. Zip				10		of What Cou	intry?
020	or items 23	by Funeral		LDER STE	12. Was Daced Armed Ford	as? XNo		21.5 Was Daced f Yas, spec 1 □ Yes	lant of l	an, Maxicar	gin? (Spac n, Puarto Ri	ify Yas or No- icen, atc.)	14. F	S.A. Raca - Amari Black, White	
Maryland 21215-0020	be filed within tal Hygiene. Ind other than event, the Mer	Be Completed	(Spe Elementary/Sec UNKNOWN 17. Fathar's Name ROY C. S	ondary (0-12)	greda complatad) Collega (1-4	4or 5+)		dant's Usua kind of wo DO NOT us	rk dona sa ratira	during mos	er's Name (	(First, Middle, Mi	HON aidan Sum	_	ndustry
altimore, Maryl	t. Pages 1 end 2 shr trment of Health end tant: If item 27 Is m jury or other traum	То	19a. Informent's N ALVIN LI 20e. Mathod of Dis	TTON / Special control	S Ramoval from St	lata ca	ROUTE laca of Dispo amatary, crar SET ME	E 2, I sition (Nam matory or o	30X na of thar pla	t end Numbe 108-E	F or Rural	Routa Number, SER, WV Data 20	City or Too 267	206	own, Stete
Ba	Physician /Medical Examiner		23a. Part 1. Entar shock, or ha Immadiete Ceusa disaasa or conditi resulting in daath)	(Final	omplications that cau only one ceusa on aad	Influe	U 2 Do not ant	PCHUR 02 GR ar tha mod	CH I	FINER	AT. HO	ME, P.A. BERLAND, raspiratory arras	MD	21502	Approximata Interval Batween Onsat and Death
Box 68760,	eath certificete be executed ettending physician end I for use as the buriel-transit	Physiclan/Medical Examiner	Sequentially list critically list critically list critically any leading to it cause. Enter Und Cause (Disease of that infilieted evenirasulting in death)	r injury	c. d.		as a conseq							1	
P.O. B	at the death I by the etter steched for u	hysicla			s contributing to deal			, ,				23b. Did tob			to the cause of death?

To the Hospital or Attending Physiclan: The lew requires the within 24 hours efter death.

Var be Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be

Division of Vital Records,

Completed by Be Medical Certification: To

5 MS

State Registrar

25. Was cese referred to medicel examiner?

5 Pending Invastigation

6 Could not be determined

1 Yas 25 No

27. Mannar of Deeth

Natural Accidant

3 🗆 Suicida

29a. Certifier

4 🗌 Homicida

hypothyroid, chronic intermittent GI bleed

26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Inpatiant 2 ER/Outpetient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28a. Pface of Injury - At homa, farm, street, factory, offica building, etc. (Spacify)

24a. Was en autopsy performed?

24b. Wara a utopsy findings available prior to completion of ceusa of death?

1 ☐ Yas 2 ☐ No

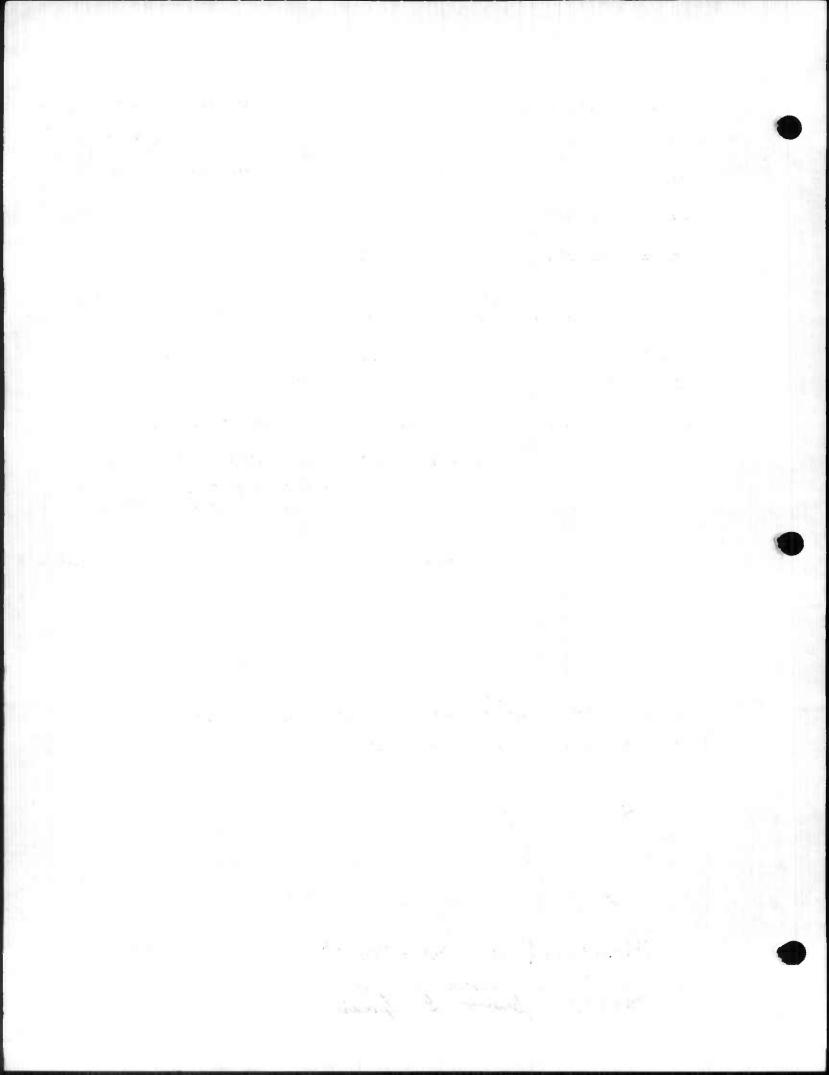
1 Certifying Phyalcian: To the bast of my knowladga, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bast of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) D26650 12/30/99

led ceusa ol death (Item 23e) (Type, Print)

13079 Garrett Highway Margaret Kaiser MD Oakland MD 21550

31. Data files AND 1 2000 32. Registrar's Signatur



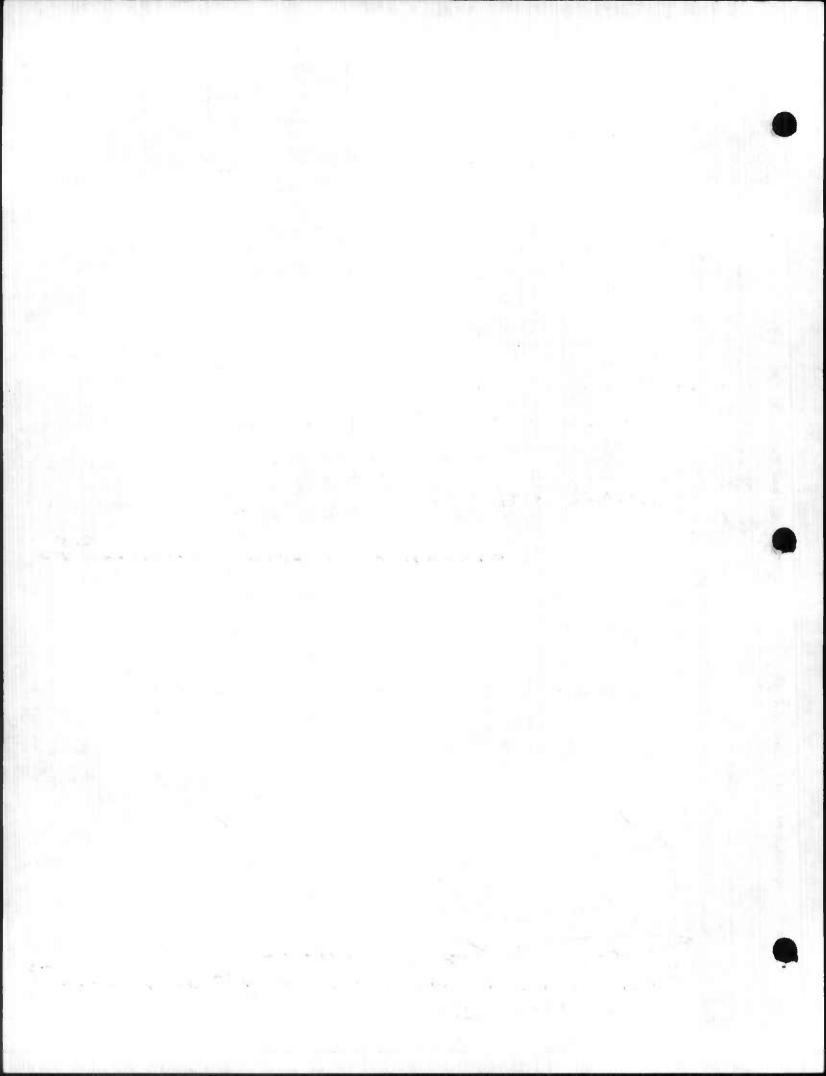
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** December 28, 1999 12:05 AM Langford Stephen /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick 7103 Autumn Leaf Lane Frederick If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth Nov. 10, Year 923 9. Birthplace (State or Foreign Funeral Deys Months Hours 15 M 2□ F England 76 228-68-8532 Director Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show rount be notified at Frederick Frederick Maryland 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 21702 10g. Citizen of What Country? 8 U.S.A. 7103 Autumn Leaf Lane "natural", or items 23s Funerai Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U.S. Armed Forces? 14. Rece - American Indien, permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or having injury or other trauments. Bleck, White, etc. 1 Yes 2 No If Yes, Give X Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Foreman Manufacturing 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be Nellie Pearson Langford Frances Stephen 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tntormant's Neme/Reletionship (Type, Print) 7103 Autumn Leaf Lane, Frederick, Md. 21702 Mrs. Joan K. Langford, wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Smithsburg Crematory, Dec. 29, 1999 Smithsburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility Keeney and Basford P.A. Funeral Home MO0255 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Intervel Between Onset end Death **Physician** 2.5 /Medical Immediete Cause (Finel 4-3 ex ETASIUC C-100 disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and s the burial-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence ot): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown been signed by should be detec p 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residenca 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel
2 Accident 5 Panding deeth. 1 ☐ Yes 2 ☐ No To the Hospital or Atlandi within 24 hours after death.
To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, term, street, tectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and mennar as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar mb

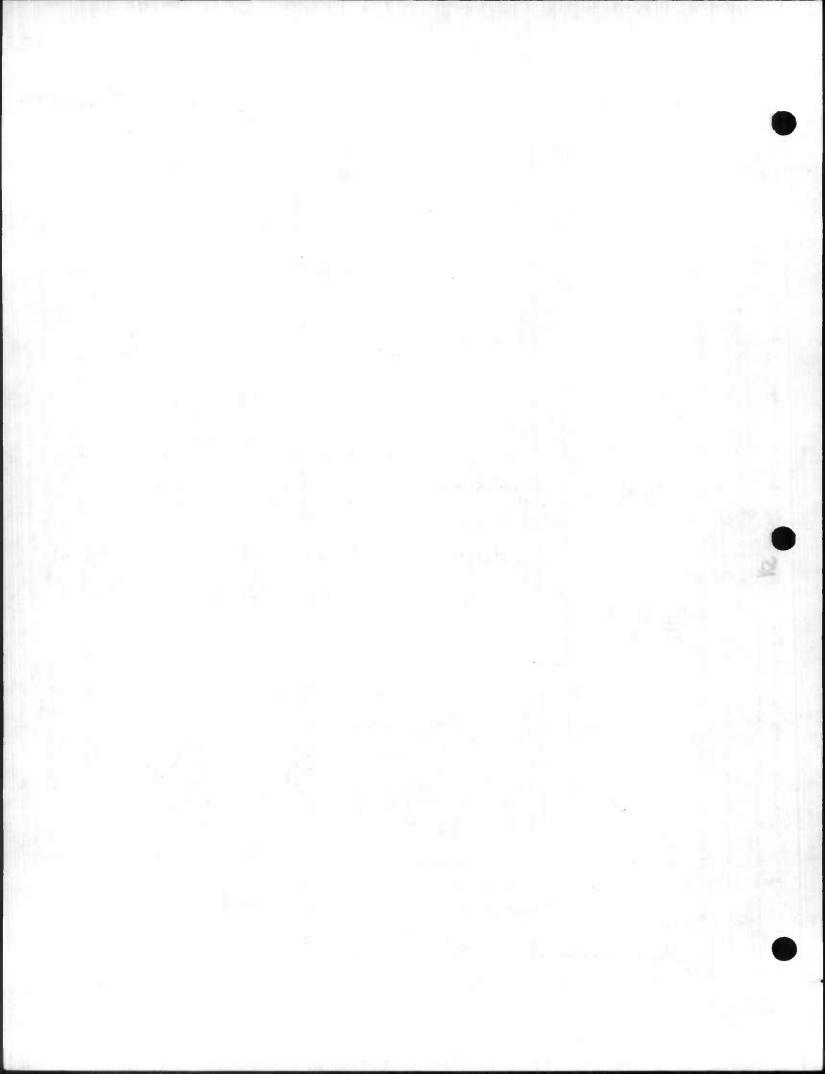
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

December 28, 1999



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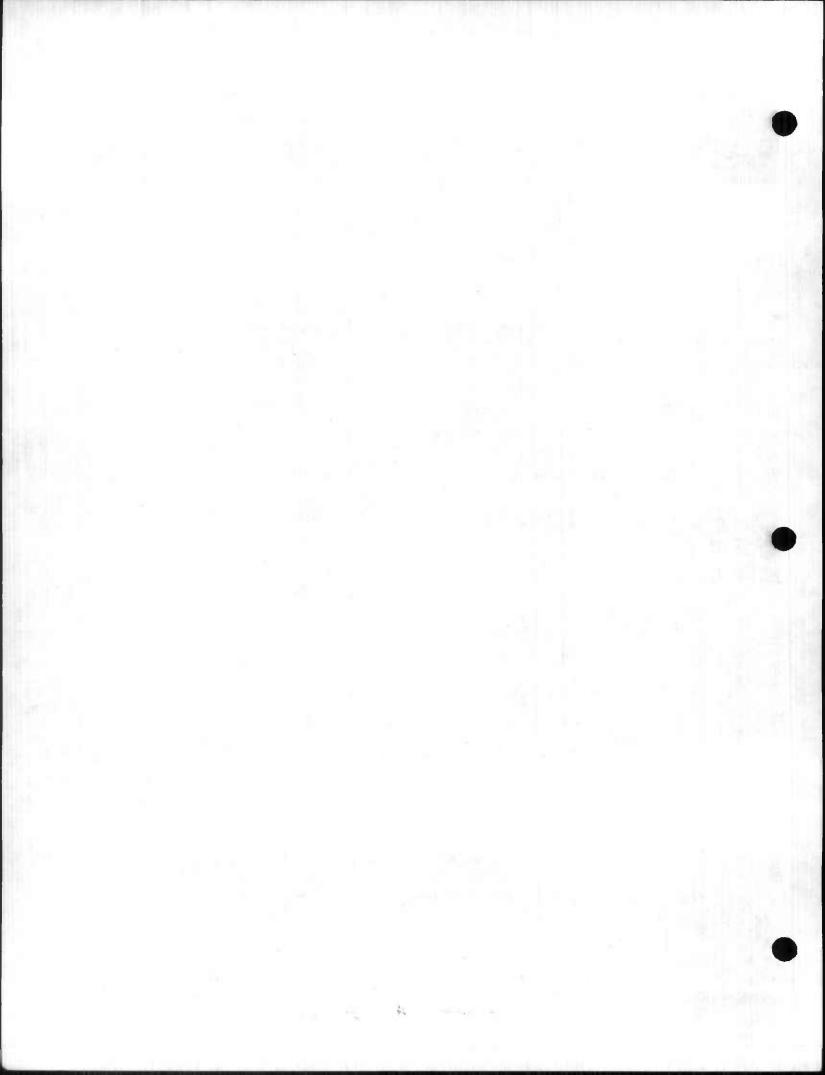
					Cer	tificat	e of	Death		R	leg. No.			
DI VIV		1. Decedent's Neme (First, Middle, L	ast)							2. Date of Dea Month	th Day	Year		e of Death
Physici Medic		Mary Louise Lust							1	December	27 1	999	12:	30 PM
Examin		4e Facility Name (If not institution, ga 43 East "C" Stre						4b. City, To Bruns		ocation of Death		ty of Death rederi		
Funeral Director			Sex 7. Ag 1 M 2 XF	e (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min,	8. Date of Birth (Month, Day May 16	1936	9. Birth Cou Wever	placa (Stantry) CTON	MD
with the Manyland a or 28a-f show be notified at	101	10a. State 10b. County MD Freder	ick	10c. City, To		cation								le City Limits
with the Se or 28s	i Director	10e. Street and Number 43 East "C" Street	et			10f. Zip	Code 716			1	Og. Citizen o	What Cou	ntry?	
n 72 hours after death with the Maryla *natural*, or hams 23s or 28s-f show sidical Examiner must be notified at	by Funeral	11. Meritet Status  1 Never Married 2 Married  3 Ø Widowed 4 Divorced	12. Wes Decedent Armed Forces?  1  Yes 2 2 1 If Yes, Give Yeer or Dates:	7.	- 11	Vas Deced Yes, spec	cify Cub	an, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ice - Ameri eck, White, ify: W		n,
with with the Man	Completed	15. Decedent's Elementary/Secondery (0-12)		5+)	Sa. Deced (Give I life. D		Il Occup rk done se retire	pation during most ad)	t of work	ing	16b. Kind of		dustry	
Vidito fied Mental Hygi rhad other dise event, il	To Be C	17. Father's Neme (First, Middle, Las								• (First, Middle, Longe)		ıme)		
	<i>574</i>	19e. Informant's Name/Relationship  Jack Lust, Jr.	(Type, Print)	1						al Route Number			5430	
Special Control of the Control of th	Ì	20a. Method of Disposition  1X Burial 2 Cremetion 3 4 Donetion 5 Other (Spec			tery, crem	ceme	ther pla		1		20c. Location			е
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsoa illia			John	T.		ams	Funeral		МЪ	017	16
Physician		Barbara A. Wil 23a. Pert1. Enter the disease, or con shock, or heert failure. List onl	nplications thet caused	the deeth. D	o not ente	the mod	e of dyi	ing, such as	cardiac	oad Bri	unswic	K, MU		
/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)	. Abd	omin			ecc	inon	ma	tosu			9	m
pe risit	miner		b	Due to (or as								1 i		
certificate be executed thing physician end use es the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	c	Due to (or es								-		
auth certificate be executed attending physician and for use es the burial-transit	Σ	resulting in deeth) Last	d	Due to (01 es	o consequ	Jones Ory.						t		
d by the detached	y Physician/	Pert It. Other significant conditions	contributing to death b	ut not resulting	in the un	derlying c	ause gi	iven in Part I		23b. Did to	/			use of death?
	Completed by									24a. Was a perfor	an autopsy med?	64	/ere autop vailable p ompletion death?	psy findings nor to not cause
dclen: The law certificate has b rector, page 2 s	Be Com	25. Was case referred to medical						26 Place	of Deat	1 □ Y		1	□Yes	2 No
Physician: this certific	ToB	exeminer?	Hospitel: 1 ☐ Inpatie	ent 2 PERA	Outpatien	3 DC	A Ot	hor		ome 5 Resid		ther (Speci	ifv)	
or Attending Physics of a steril deeth.  Director: After this din by the funeral di		27. Menner of Death  1 Neturel 5 Pending 2 Accident investigetic	28a. Dete of Inju (Month, Da	iry 28t	o. Time of injury		8c. Inju			28d. Describe h				
or Atterdee	Certification:	3 Sulcide 6 Could not determined			ferm, stre	eet, factory	, office	E		28f. Location (S City or Tow		nber or Rui	ral Route	Number,
To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edica		hysician: To the best of miner: On the basis of end menner ste	examinetion										use(s)
To the within To the comp	×	29b. Signature and title of certifier	mler i	10		-	0	se number 4 8   8	4	1	Dec	29.	1999	er)
	4	30. Neme and address of person who Elhamy Eska	noter, MD		a) (Type, 1 5 0 \	Print)	7	1th 5	tree	+ Fre	derick	- MI	2	1701
Sta Registr		31. Date filled (Month, Dan EC 3	0 1999 Registr	Signatura	~	B.	Je.	bas						
HANN 16 Day 6/06							1		-					



State of Maryland / Department of Health and Mental Hygiene

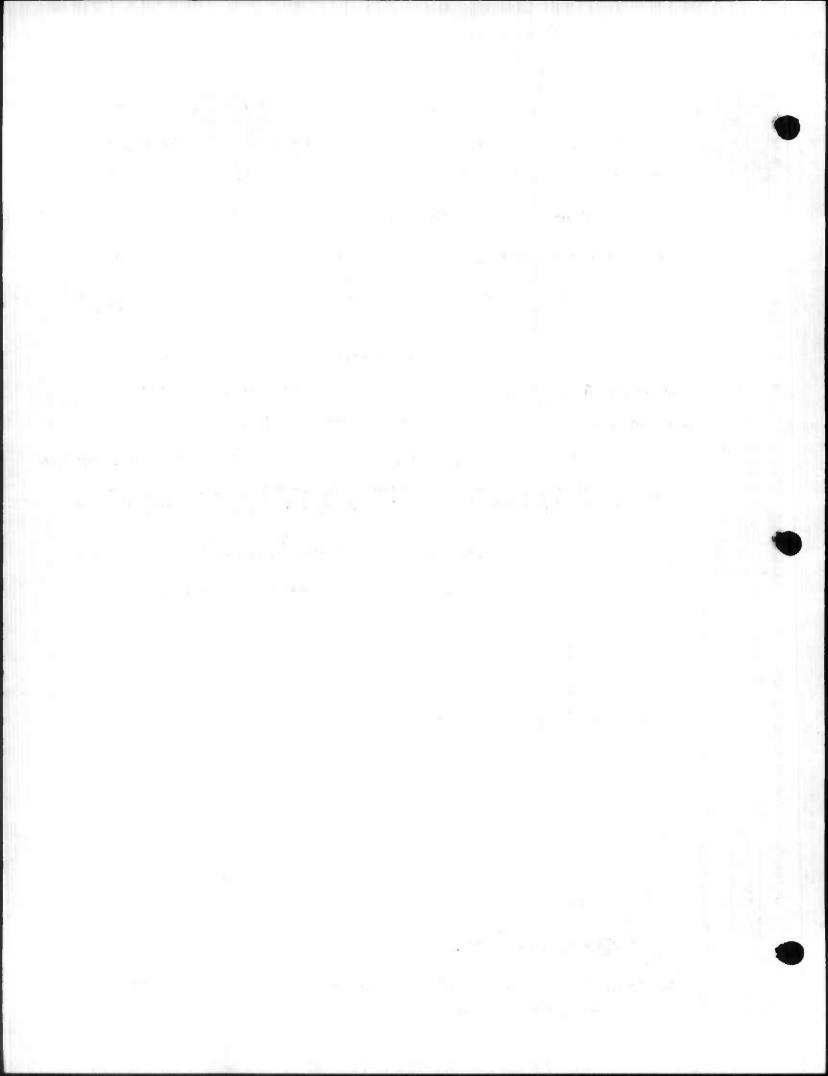
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40	000	0	Lives	~	100	

						Cert	ificate c	of Death	1	R	eg. No.		1 1.3 0	
			1. Decedent's Neme (First, Middle, L.	est)						2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physicia /Medica		Walter Lee Lyer	ly						Decembe			3:30	a.m.
	Examine		4e Facility Neme (If not institution, gi	ve street and number)				4b. City, To	own, or Loc	cation of Death	4c. Count			
			8751 Treasure A						kersy			lerick		
П	Funeral			Sex 7. Ag 1☑M 2☐F	e (In yrs. last b	Yrs.	Months Da		24 Hrs. Min.	8. Date of Birth (Month, Day			place (State or	Foreign
L	Director		214-36-0280 Usuel Residence of Decedent	A -	62	110.				Oct. 15	1937	Mary	land	
	hand was	1	10a. Stete 10b. County		10c. City, To	wn or Loca	ation					1	0d. Inside Cit	y Limits
	Man in the state of the state o	Į.	Maryland Freder	ick	Walk	ersvi	ille						1 ☐ Yes	2 No
	r 28	Director	10e. Street and Number	Lon	1 1101221	.010	10f. Zip Cod	0		1	0g. Citizen of	What Cour	ntry?	
	th wit	<u>a</u>	8751 Treasure	Avenue			21	793		_ 1	United	State	S	
	r dea	Funeral	11. Merital Stetus	12. Wes Decedent Armed Forces?		13. W	es Decedent o	of Hispanic Or Juban, Mexica	rigin? (Spe	cify Yes or No- lican, etc.)		ce - Americ		
020	0 0	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Yeer or Detes:			□Yes 2011				Specia	-1-	nite	
21215-0020	natural,	Completed	15. Decedent's E		16	a. Decede	nt's Usual Oc	cupation			16b. Kind of B	Jusiness/Inc	dustry	
21	within 7 ene. then "n	De la	(Specify only highest gr Elementery/Secondary (0-12)	Cottege (1-4or	5+)	life. DO	nd of work do NOT use re	ne during mos tired)	St of Workin	ng .				
		000		1		chan:	ical e	ngineer	:		Orbita	ıl Sci	lences	
pu	2 should be filed within and Mental Hygiere. Is marked other than summit a vent, tre M	Be	17. Father's Name (First, Middle, Las	1)						(First, Middle, I		ne)		
Yla	should ind Men	၉	Walter A. Lyer	_ <del>-</del>					iriam	House				
Maryland	12 sh h and la m		19a. Informent's Neme/Reletionship			di series				Route Number				
	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked other or other traumatic avant,	-	Daryl M. Lyerly 20a. Method of Disposition	/ wife					., Wa.	lkersvi	LIE, ML 20c. Location			
Saltimore,	00-2		1 ☐ Burial 2 ☐ Cremetion 3 [				tion (Name of story or other							
	permit. Pag Department Important: I any Injury o	-	4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lical Control of Service Lical Con	**	Hager		n Crema			2/27/99				
Ba	Departme Importan any Injur		garque lin	17.	)	22.1	Maille elle Au	uress or Fecil	" Sta	uffer F	uneral	Homes	3	
		4	23a. Pert1. Enter the disease, or con		1 th - 1 - th D					ke, Fre		, MD	21702 Approximate	
0			shock, or heart feilure. List only	one cause on each li	ne.	HOL BILLER	the mode of	uyang, such as	S Carulac O	respiratory arr	est,	1	Intervet Betwo	Neen
	Physician / /Medical		Immediate Cause (Final	0.1 +	0	1		1	1			t		
	Examiner		disease or condition resulting in death)	· 1)1161-	id la	rcl	lamera	D4 H	hy				Sian	^
		ē		( - 1 -	Due to (or as a	conseque	ence of)	Y	/				0	
	icate be axecuted physician and s the burial-transit	Examiner	Sequentially list conditions	b. Coren	Due to (er es a	conseque	ence of):	ww	VI			1 4	Xens	
ó	an an an inial-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	noch.	1.	1 . 1	11					1		•
68760,	death certificate be assecuted estending physician and of for use as the burial-transit	edica	Cause (Disease or Injury thet initiated events resulting In deeth) Last	c. I JIMIL	Due to (or es e	conseque	ence of):	)				t	Xun	)
	ng pt	9	resulting in destity East									1	V	
800	attendii for usa			d								1		
0.	the at	Physician	Pert II. Other algnificant conditions	contributing to death b	ut not resulting	in the und	lerlying cause	given in Pert	l.	23b. Did to	obacco use co	ontribute to	the cause o	f death?
٦.	that tha ded by the detached	5	Chunni lea	al in a	1/2/1	Ya.				1 U Y	es ZONo	3 Prof	bably 4 l	Unknown
S,	8 5 8	2	CILLOTTE POR	o and	7/10	org						T		
0	v requires been sign should be	Completed	Done sheard	140 Um	I'w a	1.01	11/11			24a. Was a perform	n autopsy med?	av-	ere autopsy fi ailable prior to impletion of ca	0
Records,	hes b	ğ.	The state of the s	00000	The C		ev y					of	death?	1030
=	The L	3	V							1 🗆 Y	es 20No	10	Yes 2	No
Vital		ן מ	25. Was case referred to medical axaminer?	Managhat.					e of Death	(Check only or	10)			
0	hys hys		1 Yes 20 No	Hospital: 1 ☐ Inpatio			3LI DOA		ursing Hon		ence 6 Ot		y)	
	After funer	0	27. Menner of Death  1. □ Neturel 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury		njury at Nork?		8d. Describe h	ow injury occu	ITEG		
Division	Attanding or deeth.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	9 9	us. Athomo f	larm atma		Yes 2		8f. Location (S	treat and Num	her or Run	I Route Num	her
2	or Att	ELL	4 Homicide determined	28e. Ptece of Inj building, et	c. (Specify)	em, suee	n, ractory, on	09	-	City or Town	n, State)	DOT OF FIGURE	ii riooto reami	JOI,
	Hospital 24 hours Funeral itely filled		29a. Certifier 1 ☐ Certifying Pl	nysician: To the best	of my knowledo	e deeth o	occurred at the	time date e	nd place a	nd due to the c	ause(s) and m	anner as s	tated	
	Fun Fun	edicai		miner: On the basis of	examination a									)
			29b. Signeture end title of certifier	Λ			29c. Lic	ense number		2	9d. Date sign	ed (Month,	Day, Year)	
	F > F 0		DOM	We wall	1111		)	1)22	101		121	27/4	56	
			30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type Pr	rint)	022	, 0 (		1	1		
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					,	Cer	tificat	e of	Death		,	Reg. No.		
ì	W. J.		1. Decedant's Name (First, Middla, La	ist)						Ĭ	2. Date of Da	aath		3. Tima of Death
Ш	Physic		Ethe1	Mae Les	ishear						Month	per 20,	Year 1 Q Q Q	10:00 P.M.
	/Medi Examii		4a. Facility Nama (If not institution, gh						4b. City, To	wn, or Lo	cation of Deat			10.00 F.H.
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	land m		10a. Stata 10b. County		10c. City, To	wn or Loc	cation						1	Od. Inside City Limits
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	eath 22	era	11. Marital Status	12. Was Decadant		13 V				nin? /Sne	cify Vas or N		S.A.	can Indian,
21215-0020	should be filed within 72 hours effer death with the Maryland nd Mental Hygiene.  marked other than "natural", or items 23s or 28s-f show imatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Navar Marriad 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas' 1 ☐ Yas 2 ☒ If Yas, Giva Yaar or Datas:	?				an, Mexican  Specify:	, Puerto I	cify Yas or No Rican, alc.)	Bla Specifi	ck, White,	atc.
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o uo	Attending Physician: or death. octor: After this certific by the funeral director,		27. Manner of Death 1. Natural 5 Panding 2 Accident investigatio	28a. Data of Inju (Month, Da	ury 28b	. Time of Injury		8c. Injui		2		how Injury occur		,,
Divisi	7 4 5 C	Certification:	3 Suicida 6 Could not be determined	e 28e. Place of In	jury - At homa, tc. (Specify)	farm, stre	el, factory			-		(Street and Numb wn, Stata)	per or Aura	al Routa Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edicai C	29a. Certifier 12 Certifying Pr (Check only 21 Medical Exer	ysician: To the best ninar: On the basis o and mannar st	of axaminetion a	ge, deeth and/or inv	occurred estigation,	et the tir	me, data en pinion, daa	d place, a	and dua to that ad at the tima,	causa(s) and made and plece,	annar as s and due to	tated. o the cause(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 13:08 pm Lester Leroy MYERS, III Dec. 30, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year)
Dec. 27, 1946 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2 F Yrs. 214-48-4245 53 Maryland Director Usual Residence of Decedent 10a Stata 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 11115 Glenside Avenue horns 23a 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married b Maryland 21215-0020 1 ☐ Yes 2K No Specify: white Specify: à 3 Widowed 4 Divorced 'natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) machinist truck 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) a Pages 1 and 2 should be nent of Health and Mental in Item 27 is marked o Lester Leroy Myers, Jr. Doris Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health reportant: If Item 27 Emma Jean Myers - wife 11115 Glenside Ave., Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 1-3-00 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) a SEPSIS, WITH PISSEMINATED INTRAVADICULAR CONFUENTION Examiner Due to (or as e consequence of): physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 6 ed by the s Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ACUTE ASNAC PALLUNG by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ACUTE A ESPINATORS FAILURE 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate HEAHTIC CIRRYOSIS, LAENNEC'S Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 E Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6□Other (Specify) 1□ Yes 2□-No Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Watural 5 Pending NONG 1 Yes 2 No death. investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-31-99 D01040 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar BARRY M. COHEN

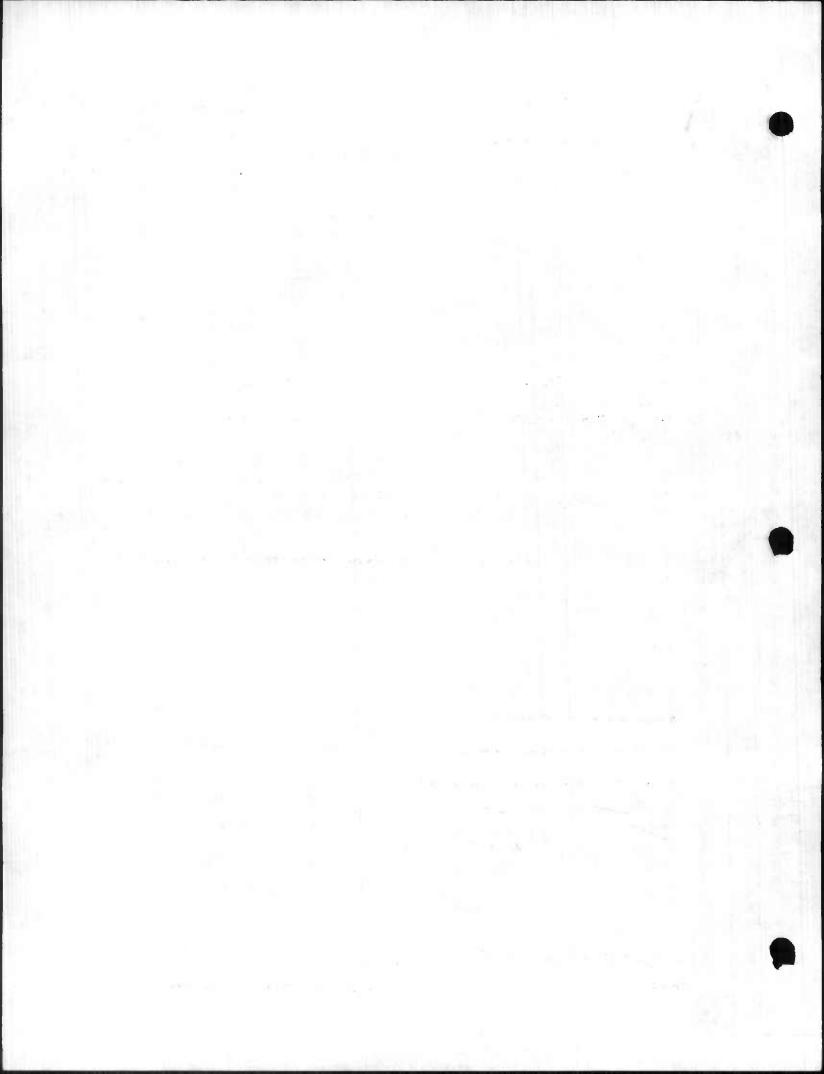
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31. Date fited (Month, Dey, Year)

DHMH 16 Rev 6/95

32. Registrar's Signature

18206 CRESTWOOD DRIVE, HAGERSTOWN -MD, 21742



State of Maryland / Department of Health and Mental Hygiene

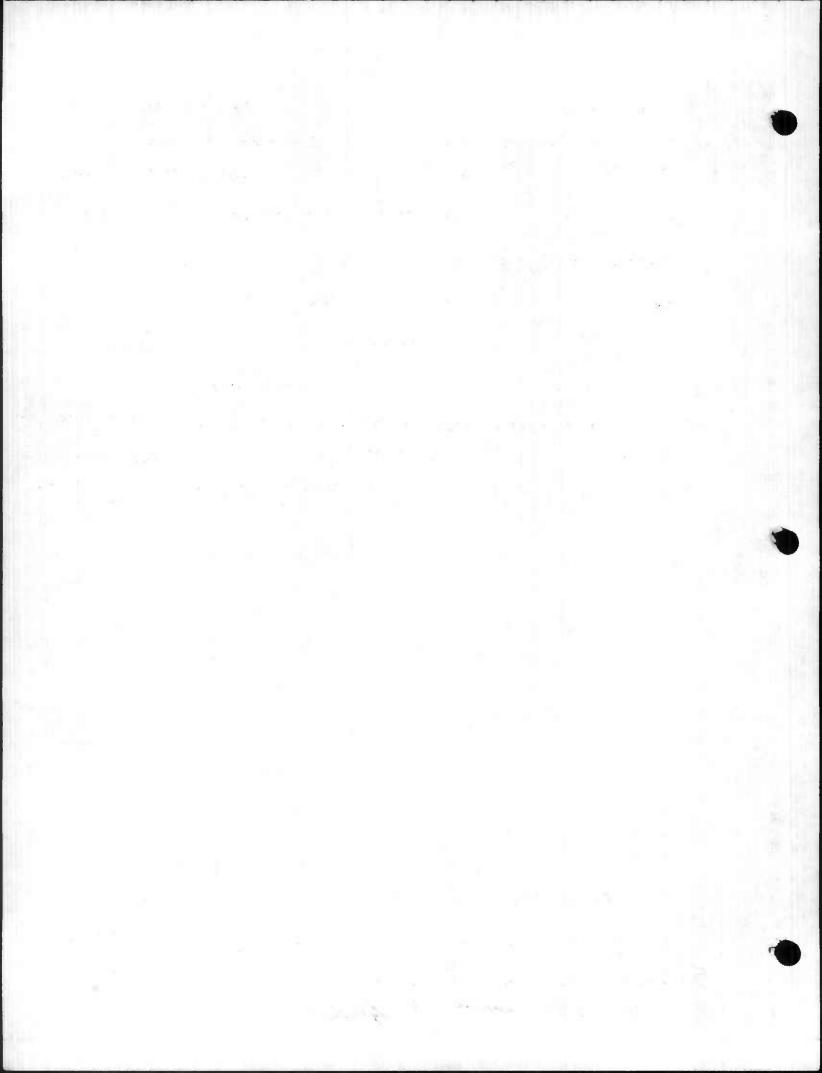
Certificate of Death 1. Dacadant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physiclan** Month Dec. 27, IRMA F. MILLER 1999 1 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Heron Point # 501 Campus Ave. Kent Chestertown If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Monthe Days Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 2∰¥ Months 220 46 1703 Vrs 93 Director Nebraska Usuel Residance of Decadent 10e. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Inside City Limits Kent Chestertown # 423 Pintail Court Yes Yes 2 No Director Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 501 Campus Ave (423 Pintail Court 21620 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Dates: NO 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or free any injury or other traumatic event. Bieck, White, etc. 1 ☐ Never Married 2 ☐ Merriad 1□ Yes 2 No No No No Baltimore, Maryland 21215-0020 by Spacify: white 3√Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 4 Collaga (1-4or 5+) Elamantary/Sacondary (0-12) Housewife in own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Frank J. Fisher Agnes V. Slazeck 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) # 423 Pintail Court Chestertown, Md The deceased while still living 501 Campus Ave # 20e. Mathod of Disposition (Neme of Cemetery, cremetory or other piece)

XXX Buriel 2 Cremetion 3 Removal from State Saint Paul's Cemetery 20c. Location - City or Town, State near Chestertown, Md. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Chestertown, Md. Willis Wells Funeral Service lis 211 Heron Point Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** week Immediete Causa (Finet disease or condition resulting in deeth) /Medical CEREBROVASCULAR ACCIDENT Examiner Examiner ATRIAL FIBRILLATION attending physician and for use as the burial-transit that the death certificate be axecuted Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initieted events resulting in deeth) Lest P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE by Records, 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? BREAST CANCER 2 No this cartificate 1 Yes 1 ☐ Yas 💥 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica etaly filled in by the funeral director, t 25. Wes case refarred to medical examiner? 26. Placa of Daath (Chack only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. tnjury et Work? 5 Panding 1 Naturel 1 Yes 2 No 2 Accident Investigation 6 Could not be datermined 3 Suicide 28e. Plece of Injury - At home, ferm, straat, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funeral C Medicai 29a. Cartifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and mannar as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated. To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D41587 30. Nema and address of person who completed causa of death (Itam 23a) (Type, Print) Dr. Helen A Noble Chestertown, Md. 21620 31. Dete filed (Month, Day, Year)
DEC 2 9 1999 32/Registrar's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

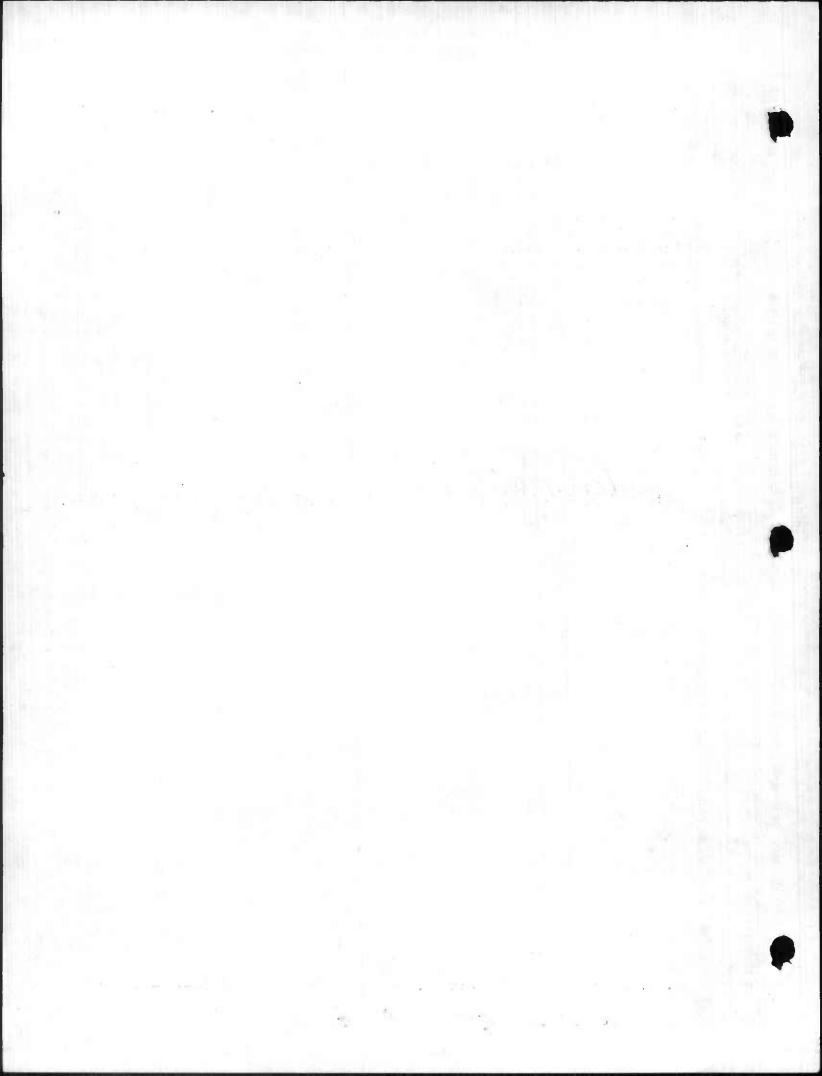


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				State of Ivia	Tyland		ificate of		, ,	eg. No.		420	70
П	Physicia	n	1. Decedent's Name (First, Middle, La	st)					2. Dete of Dea Month	th Dey	Yeer	3. Tima o	of Death
	/Medica	al	Katherine Bryarl						Dec.	24, 1		1:00	AM
	Examine	er	4e Facility Neme (If not institution, giv					4b. City, Town, or I		4c. County			
_			Reeders Memorial				If Under 1 Year	Boonsbor If Under 24 Hrs.		Washi			
	Funeral Director		5. Social Security Number 212-38-7587  Usual Residence of Decedent	M 2⊠F	(In yrs. las	Yrs.	Months Days		8. Date of Birth (Month, Dey Sept 27	1910	West	olece (Stete ntry) Virg	inia
	pung # su	ł	10e. State 10b. County		10c. City, 1	own or Loca	ation				T	10d. Inside (	City Limits
	Maryla ef show filed at	ò	MD Frederi	rk	Brur	nswick						Ye:	s 2□No
	or 28.	Director	10e. Street and Number			13111011	10f. Zip Code		1	0g. Citizen of V	Vhat Cou	ntry?	
	23e Marth	18	520 West Potomac	Street				1716		USA			
21215-0020	Par.	by Funeral	11. Meritel Stetus  **Mover Merried 2   Merried 3   Widowed 4   Divorced	12. Wes Decedent Evaluation Armed Forces?  1  Yes 2 Note of the Yes, Give Year or Detes:			as Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		k, White,	can Indien, etc. ite	
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Maryland		o Be	James Manor					Cora Na			-,		
ary	ahou man uman	-	19e. Informent's Name/Reletionship (	Type, Print)		19b. Meiling	Address (Stree	ot and Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zij	Code)	
	auth a		Eleanor Lakin, C	ousin		121 L	akin Av	enue, Boo	nsboro,	MD 217	13		
Baltimore,	Pages 1 mert of He ant: If then ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif		cem	elery, creme	tion (Name of elory or other plo s Cemet		Dete 2/27/99	20c. Location - Peters v			
Balt	parmit. Pa Departmen Important any Injury ance.		21. Signature of Fundral Service Licer Barbara A. Wil	Tiams, Owner	ani	- 1		ess of Fecility Williams rsville R			MD	21716	
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Box 68			resulting in death) Last	d	de to (or as	e conseque	erica orj.				1		
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DIVIS	s after de N Directo	Certification:	3 Sulcide 6 Could not b 4 Homicide determined	28e. Plece of Injur- building, etc.	y - At home (Specify)	, ferm, stree	et, tectory, office		28f. Location (S City or Tow		er or Rur	el Route Nu	mber,
	To the Hospital or Attending Physician; The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medicat Example 1	ysician: To the best of niner: On the besis of e end menner stete	xamination	dge, death of and/or inve	occurred et the testigation, in my	time, date end plece opinion, deeth occu	, end due to the c rred at the time, d	euse(s) end me lete end place,	end due t	stated. to the cause	(s)
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		- 1	30. Neme end address of person who Dr. Zafar Malik				-	Md 2171	2 / 201	122 04	70		
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DHMH 16 Rev 6/95

Name: Manor, Hatherine Bryarly



#### Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 42641 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 15:36 , NEWTON PATRICIA December 27 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Battimare Maryland University 7. Age (In yrs. last birthday) System Baltimore 0 If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) Months Days Hours 1□M 2XF August 30,1952 Chestertown, Maryland 220-52-2393 Usuel Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 14 Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Road K202 21620 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 WDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmotoligist Beautician 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Floyd Collins Price Grace Eva Carter 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Brian Gsell/Son 831 High Street, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBuriaf 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/99 Still Pond, Maryland Still Pond Cemetery 21. Signature of Funeral Service License 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately and the disease or cardiac or respiratory arrest, Approximately arrest, Approx Approximate tntervel Between Onset and Death tmmediete Cause (Finel Rena disease or condition resulting in death) Stage Livor diserso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Alcoholic circhosis Due to (or as e consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

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permit. Page Department of Important: If eny injury or DOCS.

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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21215-0020

Baltimore, Maryland

Examiner the burlal-transit and Physician/Medical for usa as signed by the a Completed by After this certificate funeral director, Be Certification: To To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

filled in by

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be

28a. Date of tnjury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. tnjury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one) to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MD 29c. License number P13363

Baltimore Md 21201

29d. Dete signed (Month, Day, Year) December 27, 1999

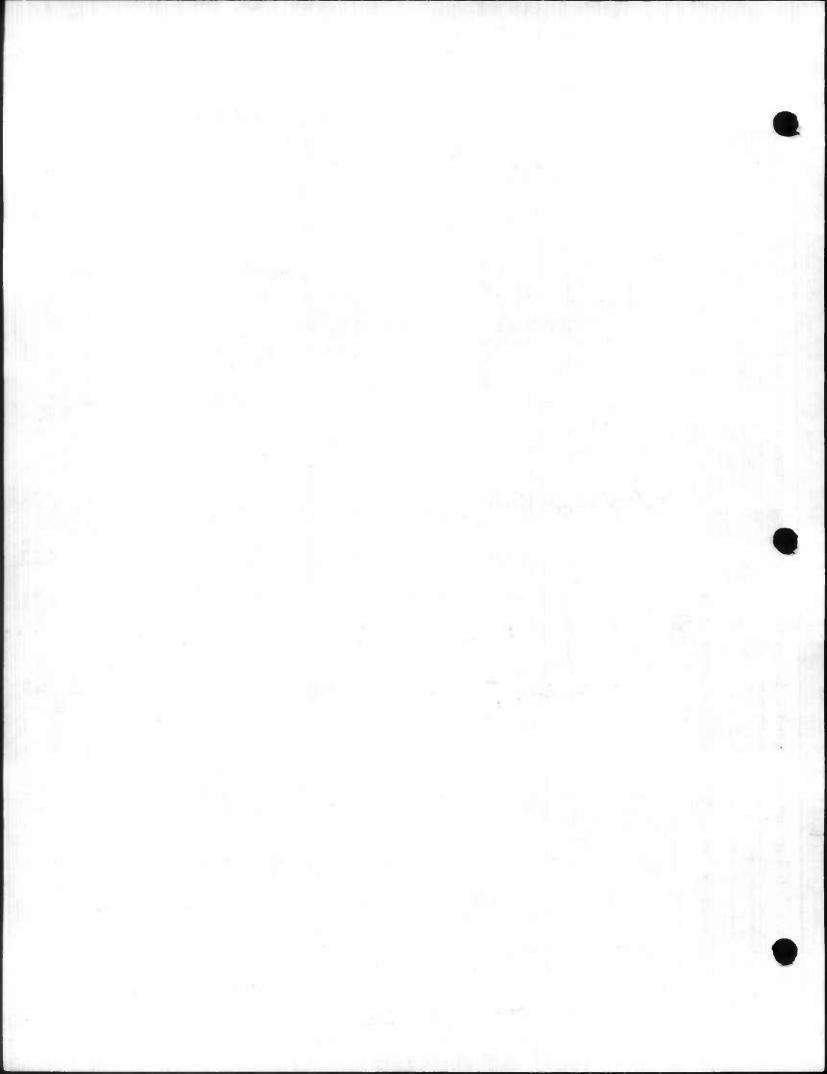
State

edical

Martin Braun, M.D 31. Date filed (Month, Day, Year) DEC 2 9 1999

22 S. Greene /32. Registrar's Signature

Registrar



State of Maryland / Department of Health and Mental Hygiene Q 42642

				Cerm	cate of	Dealli		Reg. No.		
Physician /Medical	1. Decedent'a Name (First, Middle, Li	usbaum	,				2. Date of I Month	Death Day	Year 99.	3. Time of Death 6,55 A 19
Examiner	4a Facility Name (If not institution, give College View Co	re street and number)		11 Hou-	114	4b. City, Town, o	rick	-	nty of Death	ick.
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or aff	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1943		Decedent of I s, specify Cub Yes 2∏ No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or f rto Rican, etc.)	No- 14. F	lace - Americ Black, White, city: W	
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Physician /Medical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. Sep	sis	a consequen			1		C	Interval Between Onset and Death
certificate be speculed adding physician and use as the burlei-transit nVM-edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Deep 1	Vein ue to (or aa	a consequent	> of): > om b > of):	liahe osis ure	, Altz	on mers	dem dem	entia,

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examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DO	A Other: 42 Nursing	Home 5 Residence 6 □Oth	ner (Specify)				
Manner of Death     Netural	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	Bc. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred					
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29a. Certifier (Check only one) Certifying Pt Z Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death oc ation and/or inves	curred a tigation,	at the time, date and placin my opinion, deeth occ	ce, and due to the cause(s) and mo curred at the time, date and place,	anner as stated. and due to the cause(s)				

Division of Vital Records, P.O. B

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21703 Lee MD

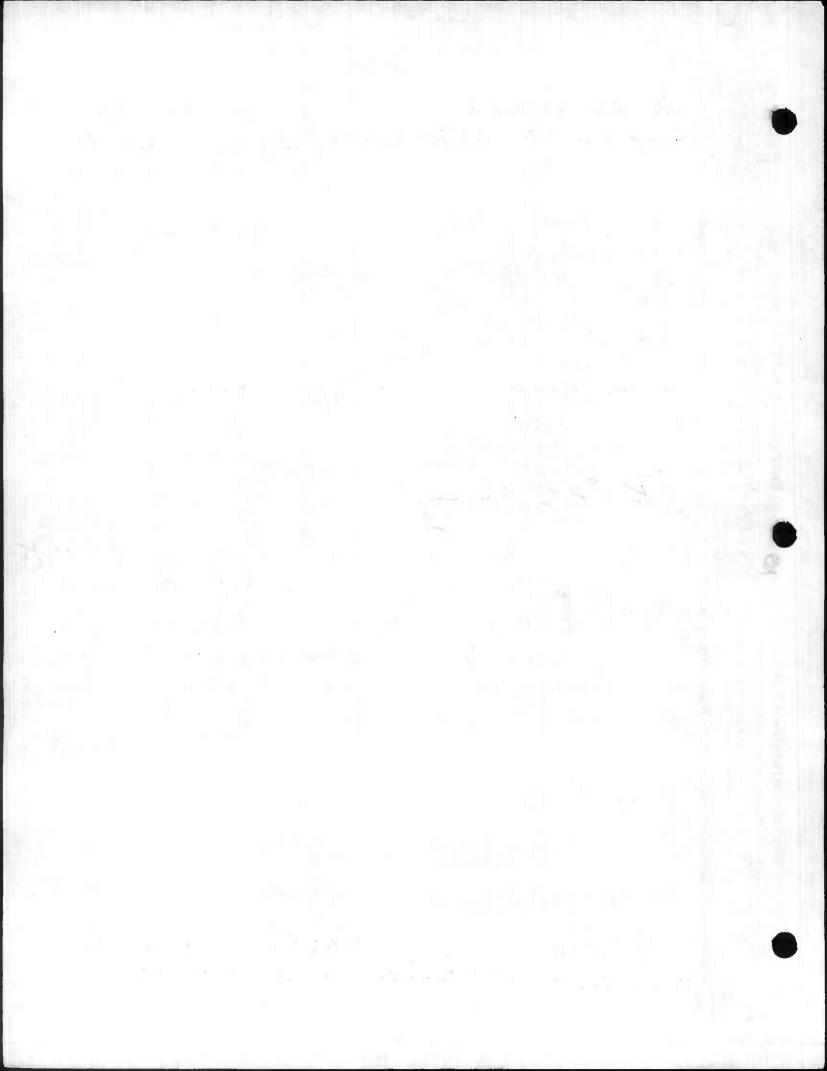
State Registrar

Medical Certification: To Be Completed by Physicia

32. Registra's Signature 31. Date filed (Month, Day, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

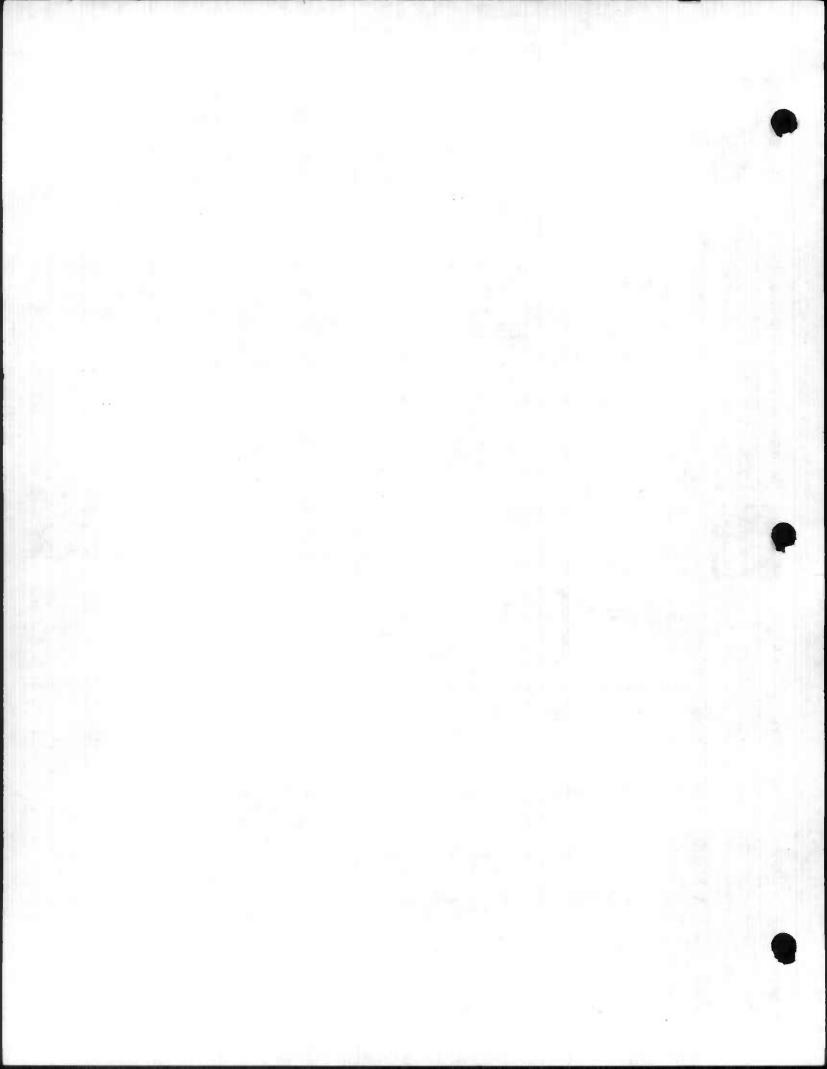
29c. License number



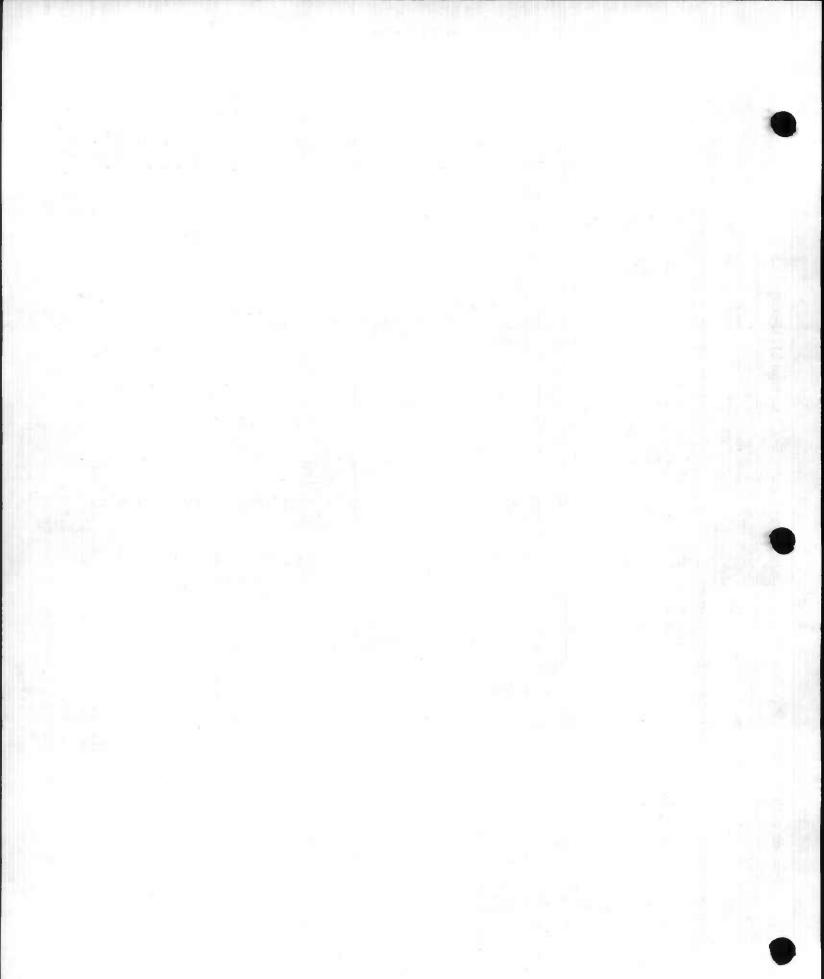
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State of Maryland / Department of Health and Mental Hygiene 9 4 264 3

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 4 26 l. L Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MERRILL PARKER HAZOLD 3-1999 06-37 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALLSTON GENERAL HOSPITAL FAL STON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Birtholace (State or Foreign Country) 5. Social Security Number **Funeral** 180 M 2□ F Days 236-52-3325 Director May 25, 1936 W. Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 20 No Directo Maryland Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be 1105 Andreas Drive Funeral 21015 USA Herns : Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after in and 10 feetile Involved them.
Int: If Item 27 is marked other than "natural", or the into or other traumate avant, me traited. 127es 2 No If Yes, Give Year or Dates: Korean 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sand & Gravel Elementary/Secondary (0-12) Cotlege (1-4or 5+) Truck Driver Manufacturer 12 Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 80 Cloyd Martin Parker Helen Kathleen Cunningham 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1105 Andreas Drive, Bel Air, MD 21015 Ruby Lane Parker/ Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State Parial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gardens 12-27-99 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 for the disease, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, heart feilura. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel CANDIO VADONI CON diseasa or condition resulting in deeth) Examiner Due to (or es a consequence of): DIOCESC Physician/Medical Examiner physician and the bural-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760. Due to (or es a consequence of) for usa P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2☑ No 3 Probably 4 Unknown by of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed ALKINSONS 1 Yes 2 No 1 Yes 2 No funaral director, 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Naturat 2 Accident 5 Pending investigation n 24 hours after death. Ne Funeral Director: Aft pletaiv filled in by the fur 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DME OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2A11 MD 21014 AVE FULFORM 218 MD 7 1999 Server State Registrar



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State of Maryland / Department of Health and Mental Hygiene

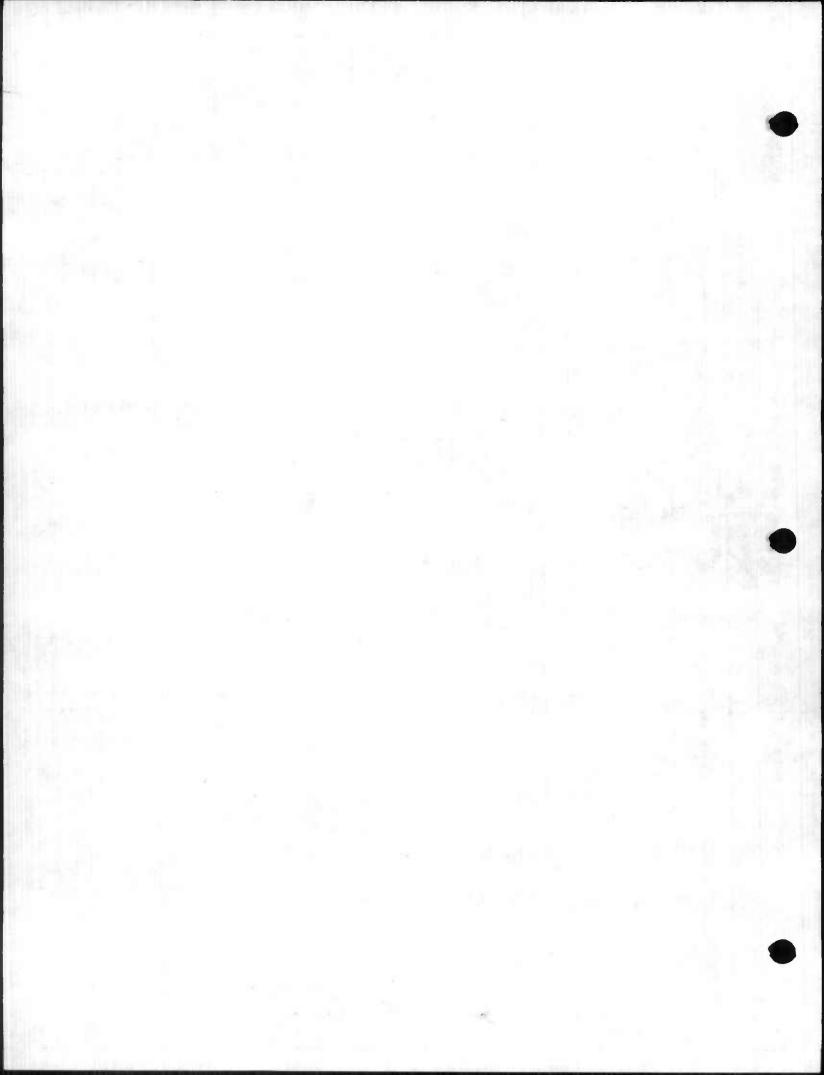
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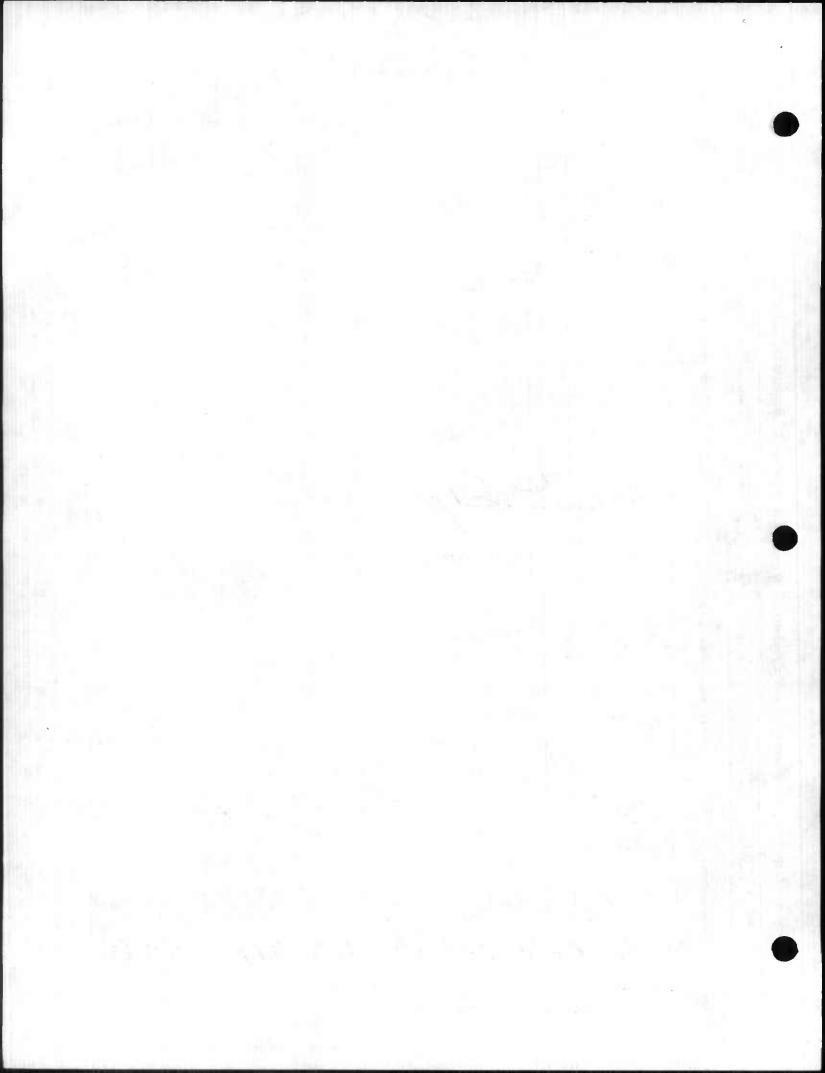
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4	21. Signature of Fuperal Served Louissee  22. Name end Address of Fecility  Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 2170													
ğ	Me	2/1/1	noto		P	onald	В.	Thompso	on Fune	ral 1	Home	01760		
	23a Parti Enter	the disease, or co	municipations that	caused the deeth								21769	pproximete	
dical Examiner	disease or condit resulting in deeth	0)	b		as e conse	quence of):								
edical Ex	Sequentially list of any, leading to cause. Enter Uni Cause (Disease that initiated ever resulting in death	1(5	C	Due to (or	es a consec	es a consequenca of):								
3			d											
200	Part II. Other sign	nificant conditions	contributing to d	leath but not resu	Iting In the u	underlying ca	use aiv	en in Pert I.	23b.	Did tob	acco use co	ntribute to ti	he cause of death?	
Physician										1 🗆 Yes	2 □ No	3 Probal	bly 4 Unknown	
by P									_				/	
B									24a.	Wes an	autopsy	24b. Wers	a autopsy findings able prior to	
e									_	penonne	ou r		pletion of causa	
Completed										1 X Yes	2 No	100		
	05 Mac	aread to see direct						00 D: 1	D th (O)	/	2 1140	1	100 ZLI NO	
Be	25. Wes case reference?		Hospitel:				Oth	pr.	Death (Check			- 15		
. To	1 XYes 2		1 1 1			nt 3 DO	A	4LI Nursii	ng Home 5 X		ce 6 Oth			
LO	1 Neturet	5 Pending		of Injury oth, Day Year)	28b. Time of Injury		Worl	Yas 2 No			D SHETE		und	
Certification:	2 ☐ Accident 3 € Suicide	investiget	be 10/2	6199	0352	AM		I AS Z NINO						
E	4 Homicide	determine	289, PI90	e of Injury - At ho ling, etc. (Specify	me, tarm, st	reat, factory,	office		City o	or Town,	State) 213	LINDER	Poute Number, J RLVD	
					Hami	E			mi	11)	aun, 1	MD		
	29a. Certifier (Check only			a best of my know basis of examinati										
edicai	one)	ZIQ MAUICEI EX		ner steted.	on endorm	reading ellori,	ar my o	onnon, ueath t	occurred at 1110		o and place,	2.10 000 10 11	50000(3)	
2	29b. Signature an	nd title of certifier		/		29c.	License	e number	1	290	d. Date signe	d (Month, Da	ay, Year)	
		()/n	11.11	mil mil	).		0	.C.M.E.	. /		Decemi	ber 31	. 1999	
	30. Neme and ede	dress of person wh	o completed cau	se of deeth (Item	23a) (Type.	, Print)		41 1 1 1 1	-		Decall	OCT DI	1222	
	_	ACK M. T		1.7			nn (	Street	, Baltin	m~~~	Max-	land 3	21201	
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State of Maryland / Department of Health and Mental Hygiene 9 9 4 2 6 4 7

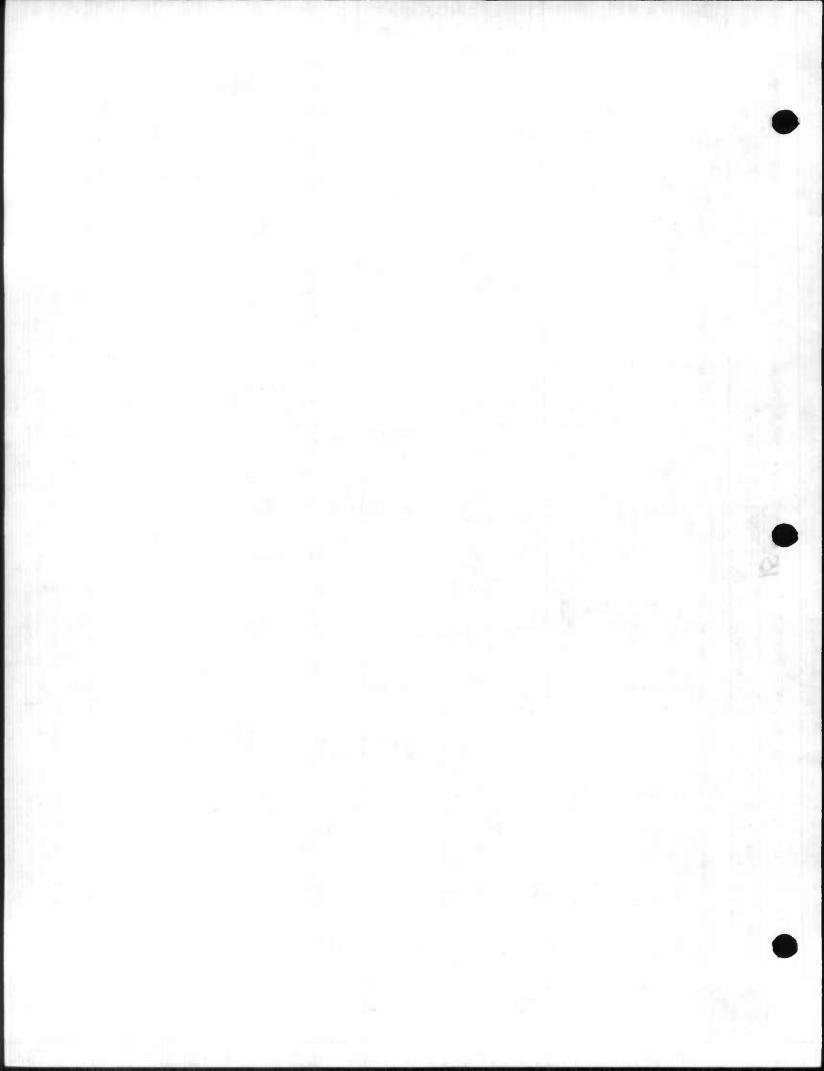
	Amended item#26per 1. Decedant's Name (First, Middla, Last		2000Cer	unicate of	Deam F(	2. Date of De		3. Time of Death			
Physician /Medical	JUNE LEN	Decemb	er 30,	1999 1628							
Examiner	4e Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death	ocation of Death 4c. County of Death				
	Frederick Memoria	l Hospital			Frede	rick	Frede	erick			
Funeral Director	212-88-0332	THE ATTE	last birthday) 7 Yrs.	If Under 1 Yaa Months Day:		Hrs. 8. Data of Birl Min. (Month, Da June 12	y, Year) 1922	9. Birthplace (Stata or Foral Country) Pennsylvania			
ahow dat	Usual Residence of Decedent  10a. Stata 10b. County  Maryland Frederic		ity, Town or Lo					10d. Insida City Limi			
oto diffe											
ma 23e or 23e-f sho must be notified at heral Director	10e. Street and Number 3857 South Mounta	in Road		10f. Zip Code 217			10g. Citizan of W	het Country?			
Example Example by Fur	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 Tas 2 Ano If Yas, Giva Yaar or Datas:		Vas Decedant of Yes, specify Cu □ Yes 2 🖾 No		? (Specify Yes or No uarto Rican, atc.)	Specify:	- Amarican Indian, c, White, etc. White			
nettur disal	15. Decedent's Edu (Specify only highast grad		16a. Deced	ent's Usual Occi	upation	working	16b. Kind of Bu	siness/Industry			
t, the Mer Comple	Elemantary/Secondary (0-12)	Coilega (1-4or 5+)		omemaker	a during most of red)	Working .	Own	Home			
Be C	17. Fether's Name (First, Middle, Last)				18. Mothar's	Nama (First, Middla,	Maiden Sumame	a)			
9 0	Clarence Snider				Bes	sie Neal					
traumer T	19a. Informant's Neme/Ralationship (7) Alton R. Putman (							Town, State, Zip Code) e, Maryland 21758			
y or other	20a. Method of Disposition 1   ↑ Burlel 2   ☐ Crametion 3   ↑ ☐ Donation 5 ☐ Other (Specify)	Removal from Stata	cametary, cran	sition (Nama of natory or other policy Lvet Cem		Data 1/4/2000		City or Town, State			
importan any injur anse.	21. Signature of Fundal Service Light	NERAL HO	MES, P.A.								
	Hotella	rough				T ST., FRI		MD 21/U1 Approximata			
sician edical miner	23e. Part1. Enter tha disease, or comp shock, or heart failura. List only o Immedieta Cause (Final disease or condition rasulting in death)	a. Courn Due to (	ty de	heise	>			Intarval Between Onsat end Death			
ial-transit Examiner	b										
physician and as the burial-transit ledical Examin	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that Initiated avants	c. Dua to (	or as e consag	nance of).							
	rasurting in death) Last	d									
I for use						1					
d by the detached	Part II. Other eignificant conditions con	ntributing to death but not res	sulting in the ur		23b. Did tobacco use contribute to the ceuee  1  Yee 2 No 3 Probably 4						
0 20							an autopsy ormed?	24b. Ware autopsy finding evailable prior to completion of cause of death?			
has pe 2						10	Yes 20 No	1 Yas 2DNo			
certificate	25. Was cesa rafarred to medicel axaminer?	1				Death (Chack only	ona)				
High P	T Yas 2D No		ER/Outpatien	1 30 DOX	Other: 4 Nursi	-	dence 6 Othe				
r: After Te fune atlon	27. Mannar of Death  1 Matural 5 Panding 2 Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. in W	juryat /ork? □Yes 2□No		how Injury occurr	ed			
od in by the fu	3 Suicide 6 Could not be 4 Homicide determined	28a. Place of Injury - At h building, etc. (Speci	noma, farm, stra ify)	aat, factory, offic	8	28f. Location ( City or To		er or Rural Routa Number,			
To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knoner: On the basis of axamini and manner stated.	owledge, death ation and/or in	occurred at tha estigation, in my	tima, data and p opinion, daath o	place, and dua to the occurred at the time,	cause(s) and ma date and place, a	nnar as stated. and due to tha cause(s)			
A DE	29b. Signeture end titla all certifier	0001	1	29c. Lica	nsa number	2	29d. Data signed	(Month, Day, Year)			
F 8	1 1000	1 400	~ \	17	174		11 -				
F 8	30. Nema and addrass of person who co	ompleted ay e of death (Ita	m 23a) (Type,	Print)	-/37	7/	19				



State of Maryland / Department of Health and Mental Hygiene

99 42648

			Certi	ficate of	Death	,R	eg. No.		-070		
	1. Decedent's Neme (First, Middle, L	est)				2. Dete of Dea		Year 3.	Time of Death		
Physician	Elbert	S. Padg	ett			Decembe	Dey 27,		2:00 A.M		
/Medical Examiner	4a Facility Name (If not institution, gr		,000		4b. City, Town, or		4c. County		2.00 A.FI		
LAdillilei	11 Rosewood	d Court Unit	105		Woodsbo	oro	Fr	ederick			
		Sex 7. Age (In yrs.		f Under 1 Year	If Under 24 Hrs	8. Dete of Birth (Month, Day	FIG				
Funeral Director		11XM 2□ F	Yrs. N	lonths Days	Hours Min.				(State or Foreign		
Director	351-09-1695 Usuel Residence of Decedent	83				May 24,	1916_	Missour	<u> </u>		
Due &	10a. Stete 10b. County 10c. City, Town or Location								Inside City Limits		
a sh									1⊠ Yes 2 □ No		
72 hours after death with the Maryland natural; or flams 23e or 28e-1 show that Examiner must be notified at etch by Funeral Director	Maryland Freder	ick Wo	odsboro						21		
or 28a-1 s	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Country?	- X		
E 139	11 Rosewood Cour	ct, Unit 105		217			United	State	S		
r heme 234	11. Meritel Stetus	12. Wes Decedent Ever in U Armed Forces?	,S. 13. Wes	B Decedent of I	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		e - American li k, White, etc.	ndien,		
1 1 E	1 Never Married 2 Merried	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2⊠No							
fatural, or forms 23e or 28e-1 show record of the call Exercises must be notified at letted by Funeral Director	3 Widowed 4 Divorced	Yeer or Detes:	10	165 200140	Specify.		Specify	Whit	e		
ygiene.  r, fre Medeal.	15. Decedent's E	Education	16a. Deceden	's Usual Occu	pation	4.7.	16b. Kind of Bu	usiness/Industr	ry		
1.8 3	(Specify only highest gi	College (1-4or 5+)	life. DO	NOT use retire	during most of wo d)	rking	New Yo	rk			
ther than out, the te	1 2	College (1-401 54)	Engir	neer			Public	Works	Dent.		
It's	17. Father's Name (First, Middle, Las	1)	- LIIGH	1001	18. Mother's Na	me (First, Middle, i			осрс.		
	Harris D. J	2-1-44									
marke marke	Harry R. I		400 11-31			Wise	G1 T.	O T- O-			
E 00 50	19e. Informant's Neme/Retetionship					ural Route Number			10)		
f Health frem 27 I other tra	Katharine Powell	L/step-daughter	2826 Wi	Idwood	Cr., Wal						
5 E U	20a. Method of Disposition		Place of Disposition cometery, cremeter	on (Name of ory or other ple	ce)	Dete	20c. Location -	City or Town,	State		
Department of Important: If He any Injury or o once.	1 ☑ Buriai 2 ☐ Cremetion 3 [ 4 ☐ Donetion 5 ☐ Other (Spec		m. of th	e Holy	Rood	1/3/00	Josthur	More	Vowle		
ortant: ortant: Injury	21. Signeture of Funerel Service Lice			eme end Addre	A F 1914						
	) garquelin	crep			St	auffer F	uneral	Homes,	P.A.		
			16	21 Opo:	ssumtown	Pike, Fr	ederick	, Md.	21702		
_	23a. Pert1. Enter the diseese, or con shock, or heert teilure. List ont	npiicetions that caused the deet y one cause on each line.	h. Do not enter t	he mode of dyi	ng, such es cardia	c or respiretory err	est,	Inte	proximete erval Between		
ysician								On	set and Death		
Medical	Immediate Cause (Final disease or condition	1 manti	IN NO	MY TIB	Priting	1			works		
aminer	resulting In deeth)	e. Conquite Due to to	or as e consequer	nce of):	LULLLO			1	vecky vecky		
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ansig	Segmentia the list and distance	b. Curcuit (c)	oras a consequer	100 m	W CICCO	CK		19	eces		
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physician and is the buriel-transit	Cause (Disease or Injury thet initieted events	c									
ge p	resulting In deeth) Last	Due to (o	r es e consequen	ice of):				t			
ding p		d.									
			-					1			
the the	Pert II. Other significant conditions	contributing to death but not res	ulting in the unde	rlying cause gi	ven in Part I.	23b. Did to	bacco use co	ntribute to the	cause of death		
T to	David Lyn. 1	Q/1200000000	101			10 Y	es 2 PNo	3 Probabl	y 4 Unknow		
be de by B	courant	Dreambo	VLU								
is of D						24a. Wes e		24b. Were a	utopsy findings		
page 2 should						perfor	med?	comple	ole prior to etion of cause		
has pe 2							1	of deat	n r		
Page Com						1 🗆 Y	es 2 No	1 ☐ Ye	s 2 No		
is certificate director, pag To Be Co	25. Wes case referred to medical examiner?				26. Place of De	eth (Check only or	ne)				
	1 ☐ Yes 2 ☐ No	Hospitel: 1 Inpatient 2	ER/Outpatient	3 DOA Ot	her: 4 Nursing h	lome 5 Neside	ence 6 Oth	er (Specify)			
	27. Manner of Death	28e. Dete of Injury	28b. Time of	28c. Inju Wo	ry at	28d. Describe h	ow injury occur	red			
\$ 5 E	1 Naturel 5 Pending investigation	(Month, Day Year)	tnjury		Yes 2 No						
by the f	3 Suicide 6 Could not l	28e. Plece of Injury - At he	ome ferm street	fectory office		28f. Location (S	treet and Numb	er or Rural Ro	oute Number.		
Director: In by the	4 Homicide	building, etc. (Specif	y)	, rootory, omeo		City or Town					
						1					
he Funer pletely fill edical	(Great only 2 Medical Exa	hysician: To the best of my kno miner: On the besis of examine	wledge, death oc tion and/or invest	curred at the ti	me, date and place pointon, deeth occu	e, end due to the curred at the time. d	ause(s) and ma late and plece.	nner as stated and due to the	1. cause(s)		
To the Funeral Directory filled in Medical Cert	one)	end menner steted.					1114.555				
To t	29b. Signeture end title of certifier			29c. Licens	se number	2	9d. Date signe	d (Month, Day,	, Year)		
	mal, and	K MMININI	. MD.	1	20395	5	12/2	7/99			
	30. Name and eddress of person who	completed sauce of death	, ,				. ~ ~	101			
					770 ((+11)-	11 20 -	-0~	nt	11 2120		
	WILLIAW A. (1)	ONVEY, M.D.	143 11	ADMIN?	AOMMO CO	U DR. F	-NEDEN	KIL, IV	10 d/10		
State	31. Dete tiled (Month, Day Year)	0 1000 Registrary Signa	iture	4	/						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth :15 PM **Physician** Month SEORGE 24 99 /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** FREDERICK HEALTH CARE CENTER FREDERICK FREDERICK Age (In yrs. last birthday). If Under 1 Yeer 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Dete of Birth 9 OCT. 21, 1923 9. Birthplece (State or Foreign Country)

3 MD. Months Deys 215-20-7841 1DX 20F Hours Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. FREDERICK Yes 2 No FREDERICK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 102 WEST THIRD ST. Funerail 21701 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Merried Y Yes 2 No if Yes, Give Year or Detes: Specify BLACK 1 □ Yes 2 No Specify: à 3 Widowed 4 Divorced Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CONSTRUCTION LABORER N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be ARTHUR PEACH ELIZABETH 2 BOWIE 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3113 WILDFLOWER CREEK DR. PAUL PEACH MARTINSBURG, W.VA. 25401

20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☑ Cremetion 3 ☐ Removel from Stete METRO CREM. DEC. 31,99 BALT. 4 ☐ Donetion 5 ☐ Other (Specify) MD. 21. Signeture of Funerel Service Licen 22. Name end Address of Fecility GARY L. ROLLINS FUNERAL HOME 00 110 WEST SOUTH ST FRED. MD 21701 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No PV Completed 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 25 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) 2

**Physician** /Medicai Examiner

permit. Peges
Department of H
Important: If ite
eny injury or ot

**Funeral** 

Director

show

death

21215-0020

Maryland

Baltimore,

Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite

Hygiene.

The law requires that the death certificete be executed and P.O. Box 68760, 6 Division of Vital Records, 8 director, page 2 should After this certificate has tal or Attending Physician: The state death.

si Director: After this certificate of in by the funeral director, pt filled in by

Other Sursing Home 5 Residence 6 Other (Specify) 204 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 D Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature end title of pertiller 29c. License number

on who completed cause of deeth (Item 23e) (Type, Print)

29d. Dete signed (Month, Dey, Year)

172 THEMOS JUHNSUN DRIVE, FREDERICK MID

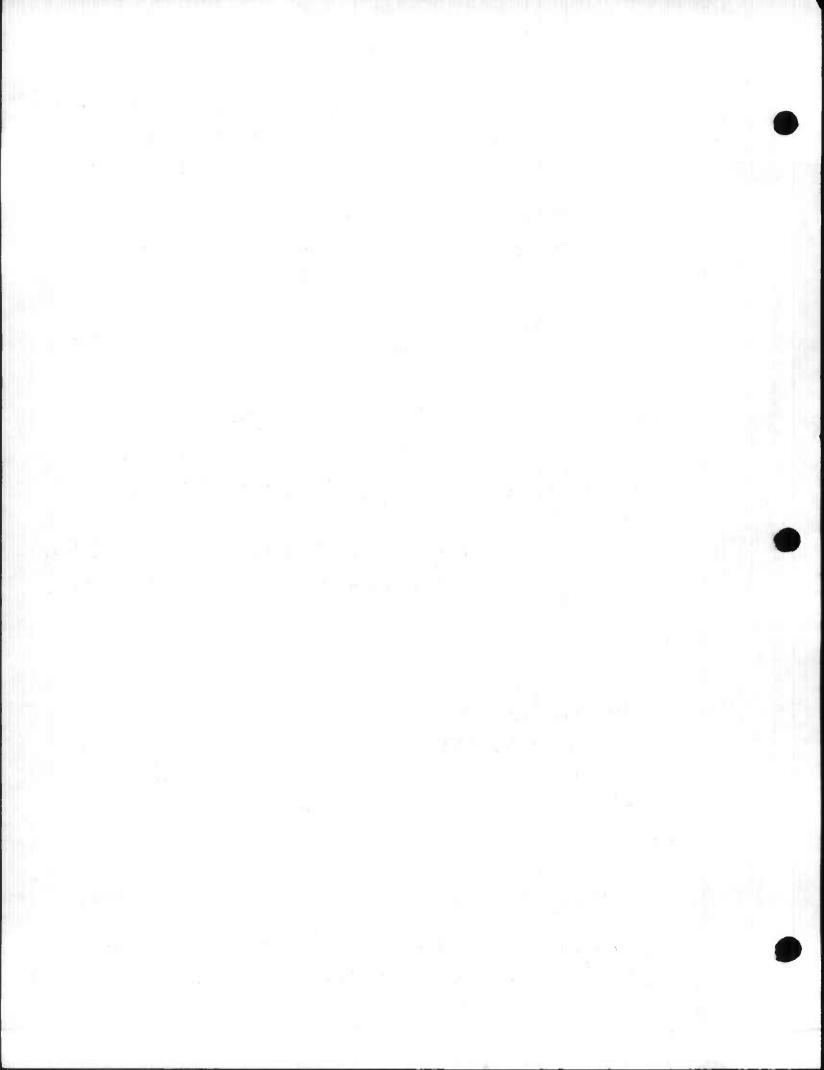
State Registrar

Certification:

Medical

31. Dete filed (Month, Da

To the Hospital of within 24 hours af To the Funeral DI completely filled in



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3:30 AM Month Physician man ecember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number, Examiner of Mary Anc Baltimone university Puns redica If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Yea Sep 1, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 20 F 216-54-7802 49 Director Maryland Usuat Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 23a-f ahow other traumatic event, tra Medical Examinar maist be notified at Howard Maryland Lisbon 1 ☐ Yas 2 □XNo Director 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 16061 A.E. Mullinux Road 21765 U.S.A. Funeral 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Never Merried 2 Merried 1 XYes 2 No If Yes, Give A JO 1 Yes 2 No Specify: Specify White à 3 ☐ Widowed 4 ☐ Divorced Year or Dales: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Heelth and Mental Hygiene. Important: if hem 27 is marked other than 'n any Injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) Husbandry (Horses) Equestrian Services 5+ 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Ralph Asper Putman Dorothy Evelyn Free 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) Shaylene Murphy Putman/Spouse 16061 A.E. Mullinux Rd, Lisbon, Maryland 21765 20b. Piece of Disposition (Name of cemetery, crematory or other place) Rocky Springs Cemetery Dec 28,1999 Frederick, Maryland 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701 M00706 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in deeth) Examiner Due to Examiner MILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of) physician a SIS Physician/Medical Due to (or es a consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy Completed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 10 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760 P.O. been signed by should be detac Records, has certificate Division of Vital Hospital or Attending Physician:
 124 hours after deeth.
 Funeral Director: After this certification by the funeral director. edical completely To the Within 2

with the Maryland

hours after

Baitimore, Maryland 21215-0020

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number

29b. Signeture and title of certifier

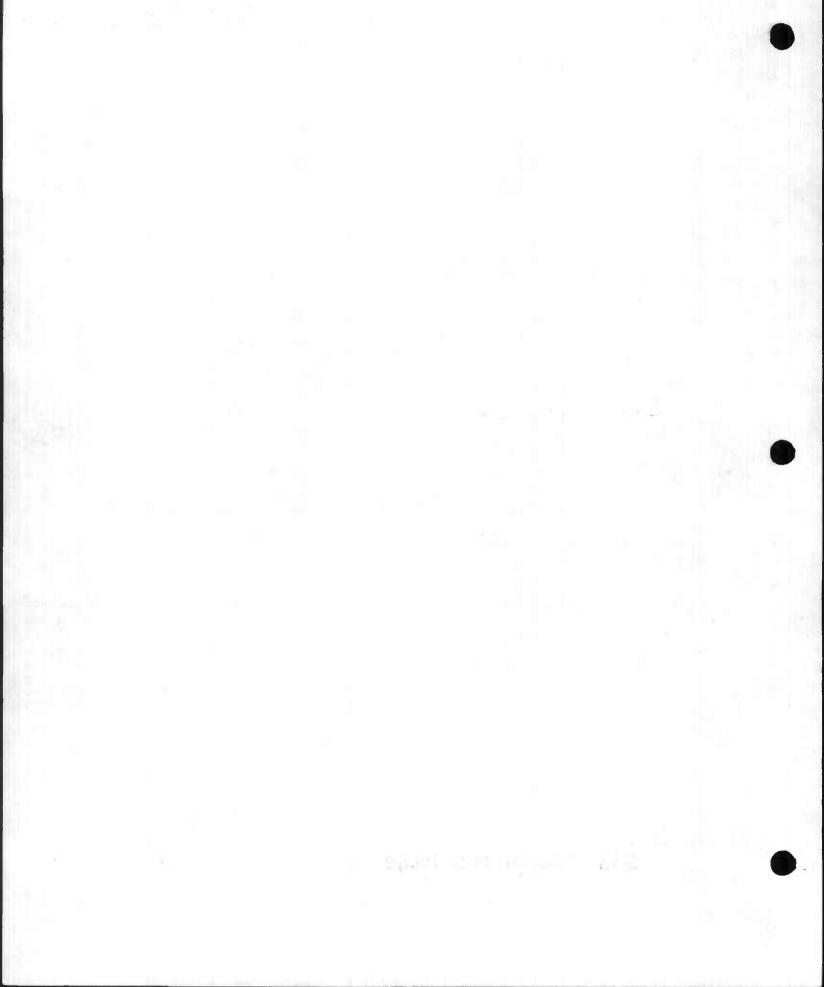
M.D 10448 completed cause of death (Item 23a) (Type, Print)

8 1999

South Greene Street, Bathmone Universit 32. Registrer Signature

State Registrar

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene O

						Cert	ificate d	of Death	R	eg. No.	J L	12051			
	Dhunia	·	1. Decedant's Neme (First, Middle, L.	ast)					2. Dete of Deet Month		Year	3. Time of Death			
	Physic /Medi		Dolores Ann	Roccofor	te				Decemb		1999	11:45			
	Exami		4e. Facility Neme (If not institution, gi	ve street and number,	)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth				
L			Union Hospit					Elkt			Ceci	1			
	Funeral Director			Sex 7. A	ge (In yrs. I	last birthday) Yrs.	If Under 1 Ye Months De			Year)	9. Birthple Countr Pennsy	ace (State or Foreign ry) Ivania			
	wo m		10e. Stete 10b. County		10c. City	, Town or Loca	ation				10	d. Inside City Limits			
	Mary Fresh	ţ	Maryland Cecil		-22		Cer	cilton			out RE	1□ Yes 2√XNo			
	or 28	Director	10e. Street and Number				10f. Zip Cod	de	1	0g. Citizen of	Whet Countr	ry?			
	th wil		645 Knight Island Road	1				21913	United States						
5-0020	within 72 hours after death with the Marylend iene. Than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Wes Decedent Armed Forces  1  Yes 2 If Yas, Give Year or Detes:	?		as Decedent Yes, specify C	of Hispenic Origin? (S Cuben, Mexican, Puer No Specify:	specify Yes or No- to Rican, etc.)		ck, White, et	e - American Indien, kk, White, etc.			
21215-0	within 72 ho iena. than "natur	Completed	15. Decedent's Elemantary/Secondary (0-12)		5+)	(Give ki lifa. Di		ccupation one during most of wo tired)	rking	16b. Kind of B	usiness/Indu	ustry			
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Maryland		To Be	Unknown	,					Dincklocker		,				
ary	SPEE	-	19a. Informent's Neme/Raletionship	(Type, Print)		19b Mailing	Address (Str				, State, Zip C	Code)			
_			Rosemarie Palmatory	- Niece		645 Kmi	ght Isla	end Road, Post	st Office B	ox 303					
altimore,	of Heal		20e. Method of Disposition	75	CE	emetary, crema	story or other	land 21913 -	Dete	20c. Location	City or Tow	m, Stete			
Ĭ			1 X Buriel 2 ☐ Cremetion 3 [ 4 ☐ Donetion 5 ☐ Other (Speci		The	Gates	Of He	011010	12/28/99	Loss	Altos	, CA			
alt	permit. Pag Department Important: I any injury o		1. Signeture of Funeral Servica Licanses  1. Signeture of Funeral Servica Licanses  1. Signeture of Funeral Servica Licanses  1. Signeture of Funeral Servica Licanses  1. Signeture of Funeral Servica Licanses  1. Signeture of Funeral Home, P.A.												
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	Physician /Medical Examiner	er	23a. Pert1. Enter the disease, or conshock, or heart feilure. List only Immediata Ceuse (Finel disease or condition resulting In death)	e.	8pr	Lentres a consaqui	dry	Jau'	luce	7 0 6	- 1	Approximete Intervel Between Onset and Deeth			
Box 68760,	certificate be assocuted nding physician and use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Undertrying Cause (Diseese or Injury that initiated events resulting in deeth) Lest	c. Caro	con	nelanes e conseque es e conseque es e conseque	S 12	breas tuens t	- BU	ne	SSien	20475 on			
Ď.	death ce	Physician/	Pert II. Other significant conditions	sontributing to death h	uit not recu	ilting In the und	ladving cause	airen in Red I	22h Didto	hacco use co	ntribute to t	the cause of death?			
0	tha by th ach	hys	Total of the significant conditions	contributing to death to	ut not resu	iking in the unc	lenying cause	given in Fert i.		s 2 No	3 Probe	/			
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Ž.	ysician: This s certificate director, pag	Be	25. Wes case raferrad to medical axaminer?	Hospitel:		_	-		eth (Check only on	ө)					
ot	S o D	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Lumpatie	-	ER/Outpetient	3LI DOA		Ioma 5 ☐ Reside						
Division	ttending death. stor: After / the fune	Certification:	1 SMaturel 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e oos Dissantia	y Year)	28b. Time of Injury	M 1	njury et Work? I 🗆 Yes 2 🗆 No	28d. Describe ho			Boute Number			
Ο̈́	oltal or A ours effer eral Directilied in by		4 Homicide data minad	building, et	c. (Specify	)			City or Town	, State)		,			
	To the Hospital within 24 hours of the Funeral Completely filled	edicai	29a. Cartifier 1 ☐ Certifying Pt (Check only one)	nysician: To the best niner: On the basis of end menner st	examineti	vladga, death o ion end/or inve	stigetion, in m	a tima, data end plece ny opinion, daath occu	red et the time, da	usa(s) and ma ite end plece,	anner as ste and dua to t	ted. ha cause(s)			
	To the within 2 To the comple	Me	29b. Signeture end title of cartifier	ld.161	Per-	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 12/21/99— am 23a) (Type, Print) ELICTON, MD21921—					ay, Year)				
			30. Name and addrass of person who	completed cause of d	laath (Itam	23a) (Type, Pi	rint) TON	mDs	2/92	/	1				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr											

State of Maryland / Department of Health and Mental Hygiene 9 9 42652 Certificate of Death

•	Physici /Medi Examir	cal	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiens.  Department of Health and Mental Hygiens.  Important: If them 27 is marked other than "natural", or items 23s or 23s-f show any injury or other treatments event, the Medical Examiner must be notified at one and other treatments.	To Be Completed by Funeral Director	
Ras Na Ke, Herman Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the bunial-transit or property.	Medical Certification: To Be Completed by Physician/Medical Examiner	

				Certi	IICalc	OIL	Jeaur			Reg. No.		129
	Name (First, Middle, La	ist)							2. Date of De Month	ath Day	Year	3. Time of Death
Herma	an Andrew	Rasnak	е						Decemb	- 4 50	1999	6:20 AM
	me (If not institution, giv	e street end number,	)			4	b. City, To	wn, or L	ocation of Deat		of Death	
Citiz	zens Nu	RSina	Hom	6		H	aure	Dr.	Grace	Ho	in fo	ord.
5. Social Secur	rity Number 6. S		ge (In yrs. last		If Under 1 Months		If Under :	24 Hrs. Min.	8. Date of Bir (Month, De		9. Birtho	place (State or Foreign
213-	16–1128	1 <b>3</b> 2 M 2□ F	84	Yrs.	vioritris	Deys	Hours	IVIII).	June 1	, 1915	Virgi	nia
	ce of Decedent											
10a. State	10b. County		10c. City, T	own or Loca	tion						1	Od. Inside City Limits
MD	Harfor	ď	Havre	e de G	race							1 Yes 2 No
10e. Street and	Number	BUILDING FO			10f. Zip C	Code				10g. Citizen of	What Cour	ntry?
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11. Marital Sta		12. Was Decedent	Ever in U.S.	13. Wa	s Decede	nt of Hi	spanic Orio	gin? (Sp	ecify Yes or No		e - Americ	an Indian,
	Married 25 Married	Armed Forces'		II Y	es, specif	y Cuba	n, Mexican	, Puerto	Rican, etc.)		ck, White,	etc.
3 ☐ Widow	ed 4 Divorced	If Yes, Give Year or Dates:		10	Yes 2	No	Specify:			Specif	Whi	te
	15. Decedent's Ed	101	10	6a. Deceder	t'e Heuel	Occups	ation	_		16b. Kind of B		
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20e. Method of	Disposition 2 Cremation 3 C	Pemoval from State	come	of Dispositi etery, creme	ion (Neme tory or oth	er plec	e)	i	Date	20c. Location	- City or To	own, State
	ion 5 Other (Specif		Bel A	ir Me	moria	al G	arder	ns 1	2/30/99	Bel Ai	r, Ma	ryland
21. Signature	of Funeral Service Licer	nsee								e, P.A.		
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disease or cor resulting in de	dition	a.	W.	1 803	Titta		0 ((-)		<i>a</i>	77 3	-	rigy.
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Sequentially line if any, leeding cause. Enter	st conditions,		Due to (or es	e conseque	nce of):						1	
cause (Diseas	Underlying	6										
Cause (Diseas that initiated ev resulting in dec	vents ath) Last	V	Due to (or es	a conseque	nce of):							
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Part II. Other a	gnificant conditions o	ontributing to death t	out not resulting	g in the unde	erlying cau	use give	en in Pert I.		23b. Did	tobacco usa co	entributa te	the cause of death?
									1□	Yes 2000	3 □ Pro	bably 4 ☐ Unknown
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									24a. Was	an autopsy	24b. W	ere autopsy findings
										ormed?	CO	allable prior to impletion of cause
											of	death?
									10	Yes 2 DNo	1(	Yas 2□ No
25. Wes case examiner?	referred to medical						26. Place	of Deat	h (Check only	one)		
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27. Manner of I		28a. Data of Inju	ury 281	b. Tima of Injury	280	c. Injury Work	at		28d. Describe	how injury occu-	rred	
t Matura 2 Accide			sy rour,	прагу	М		res 2 1	No				
3 Suicid	6 Could not be	289. Placa of In	jury - At home	, ferm, street	t, fectory,	office					ber or Run	al Route Number,
4 Homic	100	building, et	fc. (Specify)						City or To	wii, State)		
29e. Certifier	1/U Certifying Ph	yaiclan: To the best	of my knowled	dae, deeth o	ccurred et	the tim	e. date and	d place.	end due to the	cause(s) and m	enner as s	tated.
(Check only one)	2 Medicat Exam	niner: On the basis of	of examinetion	and/or inves	stigetion, is	n my op	pinion, deel	th occur	red at the time,	date and pleca,	and due to	the ceuse(s)
29b. Signature	and title of certifier		11.55		29c.	License	number		T	29d. Date signe	ed (Month.	Day, Year)
	Quian	_ MD.					609			12/28		
							- 1			1000	(1)	
30. Name and	address of person who	completed cause of	deeth (Item 23	a) (Type, Pri	int)		0.	11	A . 40 A	<i>'</i>	112	
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State Registrar

31. Date filed (Month, Dey, Year)

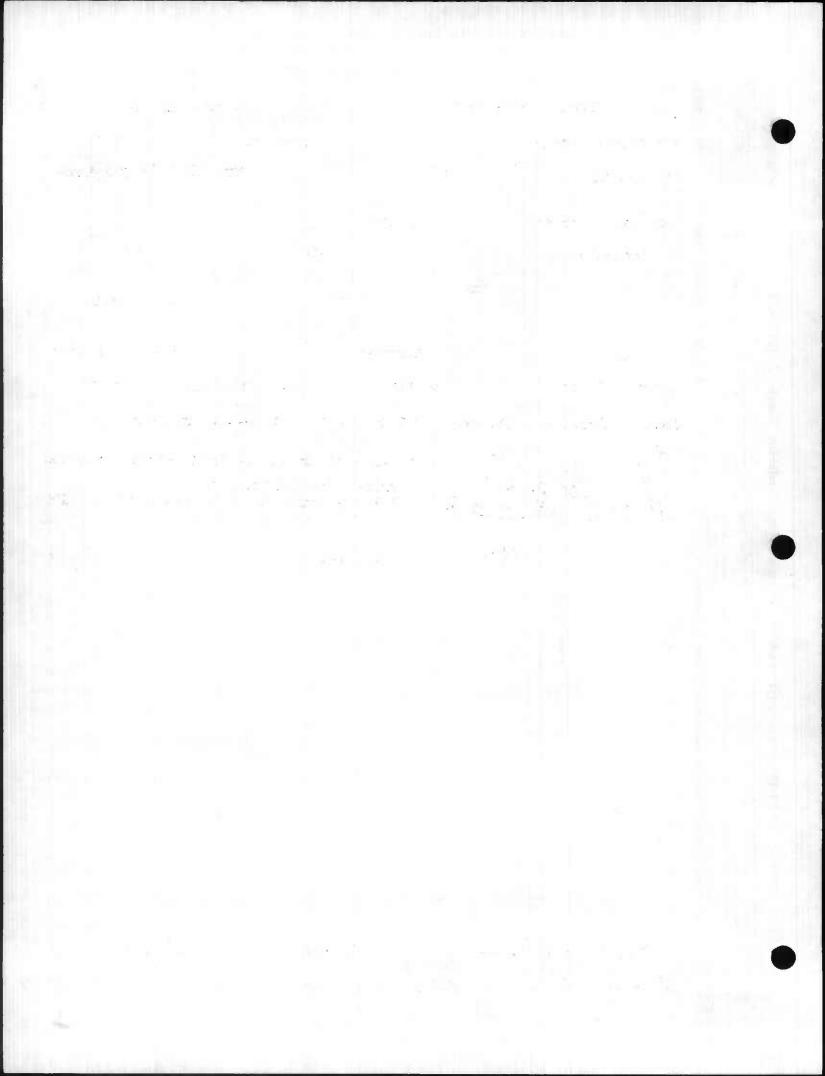
32. Pegistrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ROSE FILEN 31, 1999 RICHARDSON December 3:45 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner **Fdaewood** 207 Kennard Avenue 8. Date of Birth (Month, Day, Year) Apr. 15, 1944 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1□M 20F 55 Maryland Director 215-44-1191 the Marylend 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. Counts show 7 is marked other than "natural", or hams 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21040 USA 207 Kennard Avenue Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. Important: If them 27 is marked other than "natural" 1 ☐ Never Married 2 Married 1 ☐ Yes 20XNo Specify: Specify: White λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education Secretary 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Goodrich Leight William Rose Emory Elizabeth 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 207 Kennard Ave., Edgewood, Maryland 21040 John S. Richardson - Husband 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriat 2 Cremation 3 Removal from State 1/3/2000 Aldino, Maryland 4 Don tion 5 Other /Specify Harford Memorial Grdns. a of Funeral Se 22. Name and Address of Facility 21. Signa McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Jarcomo disease or condition resulting in death) Examiner Examiner sicien and buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien as the buriel Physician/Medical Due to (or as a consequence of): 80 USB 0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown á bengis be del Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 hes 1 Yes 2 No 1 ☐ Yes 2 XNo certificate or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 550 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) funeral 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier iU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Franklin Square Dr. Bult. M.) 21237 McCollum MID 31. Date filed (Month, Day, Year) 32, Registrar's Signature

State Registrar

JAN 0 3 2000

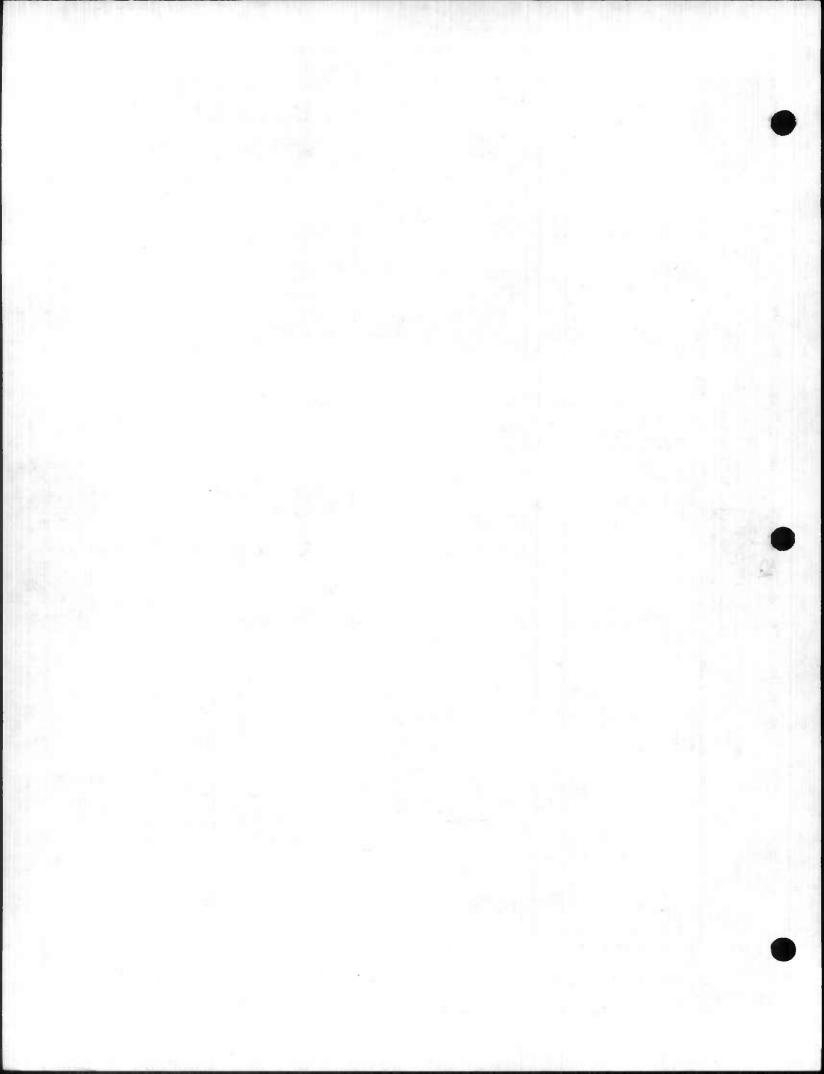


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day **Physician** DECEMBER 29, 1999 HAROLD WILLIAM ROELKE, JR 6:20 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick County If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sax 1∭M 2□ F 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Hours Months 214-42-0836 Director 56 Oct. 14. 1943 Maryland Usual Rasidence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Director Maryland Frederick County Frederick 250-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 3 East Ninth Street 21701 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc 1 Nevar Marriad 2 Married b Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Py. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usuat Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 10 custodian 18. Mothar's Nema (First, Middle, Meiden Sumema) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be fill ment of Health and Mental Hit tant: If them 27 is marked oth jury or other traumatic even Be Harold William Roelke, Sr. Airy V. Burck 19e. Informent's Neme/Ratationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health ar Important: If them 27 is any injury or other traus Airy V. Keeney, mother 3 East Ninth Street, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Buriat 2 Cramation 3 Ramovat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Olivet Cemetery 12/31/99 Frederick, Maryland 22. Nama and Addrass of Facility Keeney and Basford Funeral Home 21. Signature of Funerat Sarvice License MO0999 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Finat disaasa or condition rasulting in daath) /Medical ACUTE GASTROINTESTINAL HEMORRAME Z DAYS Examiner Due to (or es a consequance of): 2 MONTAG HEPATIC METASONSES Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last 2 MONTHS NON-SMALL CELL LUNG CANCER Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? HYPERCALCEMIA 15 Yes 2 No 3 Probably 4 Unknown of MALIGNANCY Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? 1 Yas 2 No 1 Yas 25 No of Vital Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifica 25. Was casa rafarred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas ZENO Certification: To 1 ☐ Inpatiant 2 ★ER/Outpatient 3 ☐ DOA 27. Mangar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Division Natural
Accidant 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicida Medical Examiner: On the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical completaly (Check only one) To the Vithin 2 29b. Signature and title of surtilly 29c. License number 29d. Data signed (Month, Day, Year) D31761 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) BRIAN M. O'CONDRAD SOI W. SEVENTH. ST. FREDERICK MD 31. Data filed (Month, Day Year) 3 0 1999

**DHMH 16 Rev 6/95** 

State Registrar 32. Ragistra Signatura

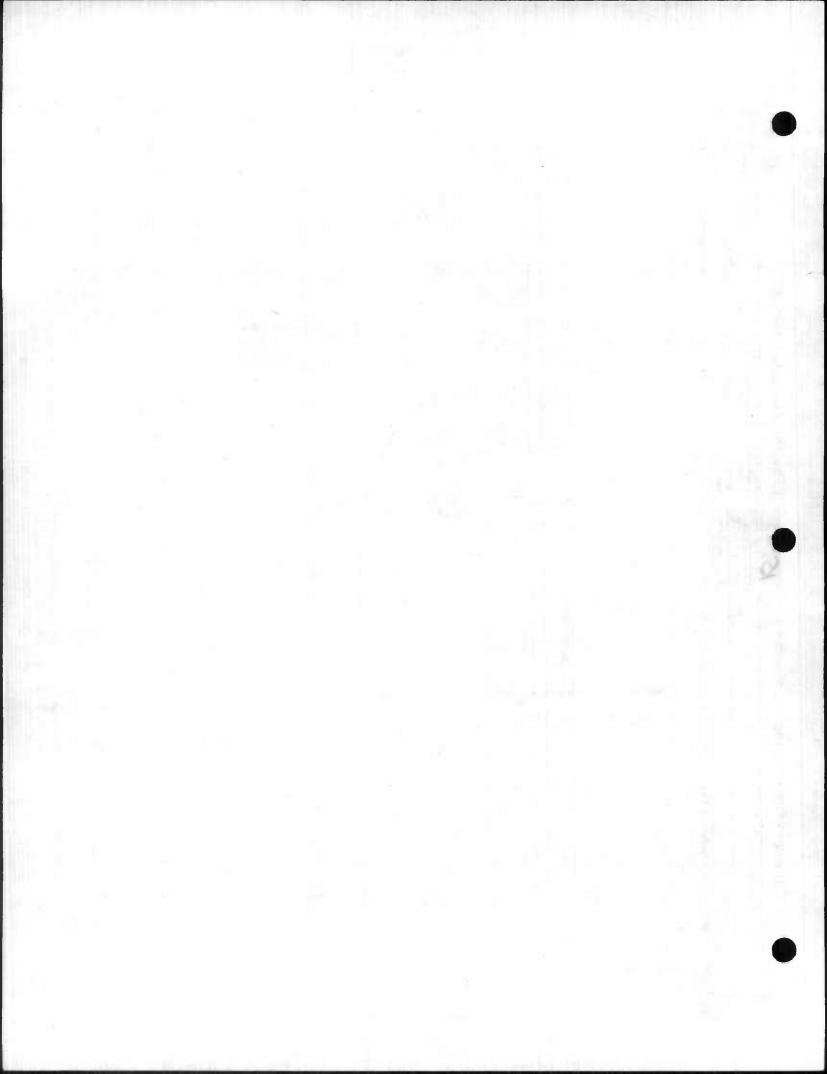


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Neme (First, Middle, Last) 2. Dete of Death Month **Physician** ner Kinnse ecember /Medical 4a Facility Name (If not institution, give stre 4b. City, Town, or Location of Death 4c. County of Death Inwersity of MARYLAND Systems BALLIMORNE edical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 XM 2 F Months Director 219-07-8994 80 July 16, 1919 West Virginia Usual Residence of Decede the Manyland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 813 Motter Avenue 21701 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hyglens. Important: If item 27 ie marked other than "natural" any injury or other treumatic average once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Type 2 No Specify White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Painting Contracter Home Improvement 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Joshua Phillip Ruffner Eva Elizabeth Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 813 Motter Avenue Frederick, Maryland 21701 Nova V. Ruffner / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Dec. 31 4 Donation 5 Other (Specify) Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Box 68760, Physician/Medical that initiated events resulting in death) Last 5 Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the detached 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown CHNCER þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient edical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

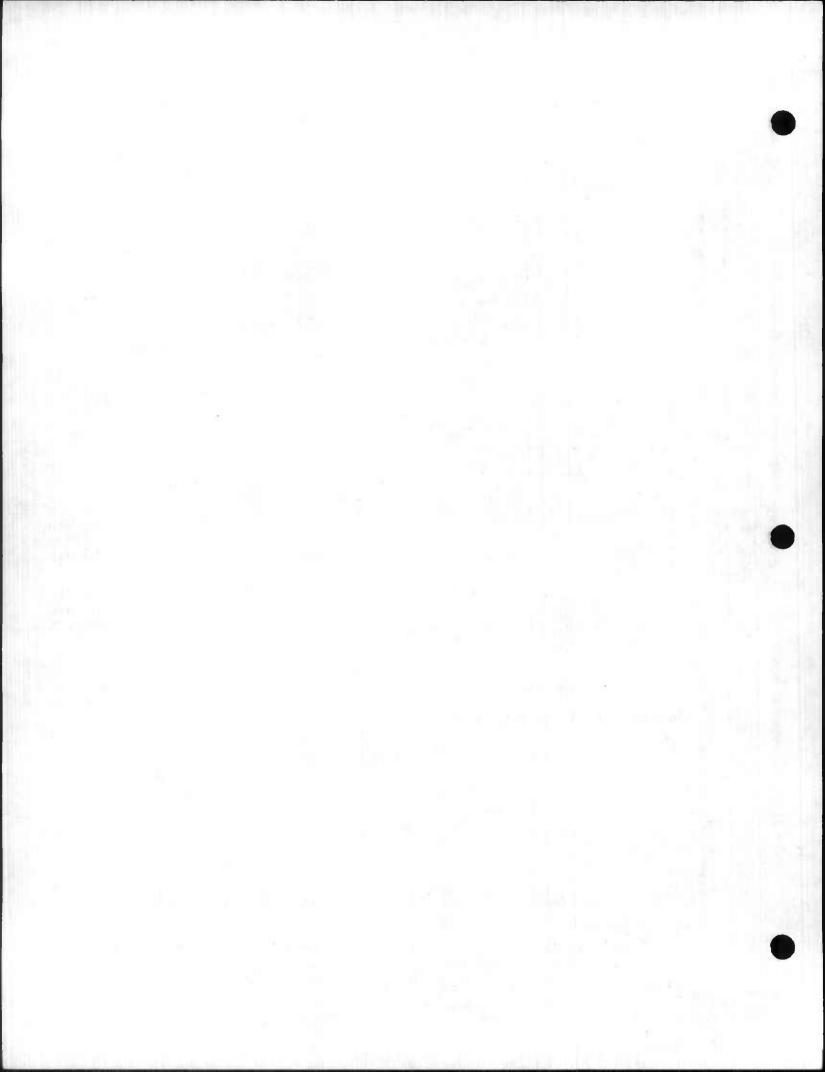
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) 1 of Maryline Greene Street Baltimore, MD pkou Universit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 3 0 1999 Registrar

DHMH 16 Rev 6/95



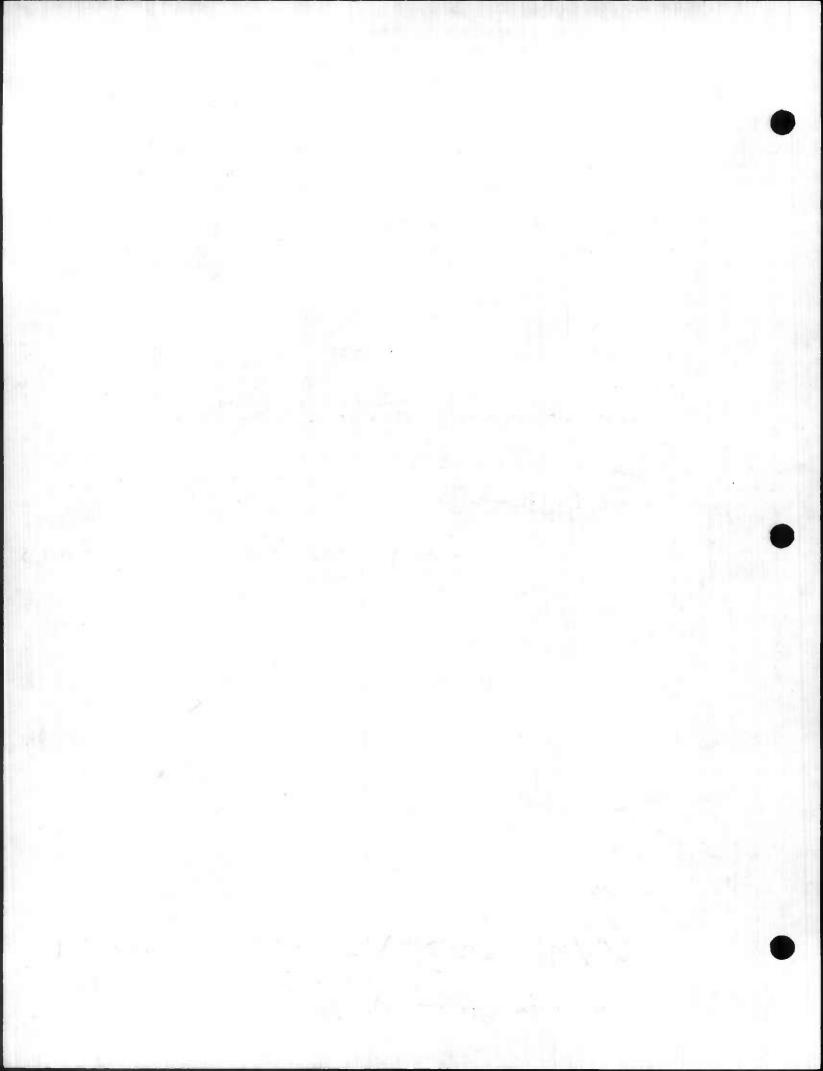
State of Maryland / Department of Health and Mental Hygiene 99 42656

			Ce	ertificate o	f Death	Re	g. No.	1 to		
Bl	1. Decedent's Nama (First, Middle, L	est)				2. Date of Death Month		Year 3. T	ima of Death	
Physician /Medical	JOHN THOMA	S ROUTZAHN	SR.			DECEMBER			:15 AM	
Examiner	4a Facility Name (If not institution, gr	ve street and number)			4b. City, Town, or I	ocation of Death	4c. County	of Death		
	Frederick Memor	ial Hospital			Frederic	ck	Fre	ederick		
uneral		(DT)	s. last birthday	Months Day	The second secon	8. Data of Birth (Month, Day,	Year)	9. Birthplace (Country)	Stata or Foreign	
irector	212-10-8228 Usual Residence of Decedent	93	Yrs.			July 30	, 1906	MD.		
ž	10a. Stata 10b. County	10c. C	City, Town or I	Location				10d. In:	side City Limits	
terms 23s or 28s-f show instricted at notified at Funeral Director	MD. Fre	derick	Mid	ldletown				10	XYas 2□No	
be notified Director	10e. Street and Number	delien	1110	10f. Zip Code	9	10	g. Citizen of W	Vhat Country?		
T O	409 E. Main	St.			21769		U.S	S.A.		
dher must	11. Marital Status	12. Was Decedent Ever in	U,S. 13	. Was Decedent o	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yas or No-	e - Amarican Inc	lian,		
_	1 Never Married 2 Married	Armed Forces?  1 Yes 2 XNo				o Hican, atc.)	1	k, Whita, atc.		
by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yas 2⊠N	lo Specify:		Specify.	White	е	
e de	15. Decedent's E (Specify only highest g		16a, Dec	edent's Usual Occ	cupation ne during most of wor	king	6b. Kind of Bu	siness/Industry	THE	
d de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)					
Completed		2		presiden	t/officer			nce co.		
B S	17. Father's Nama (First, Middle, Las	n s Routzahn				ma (First, Middle, Maiden Sumama)				
					Lucie					
To	19a. Informant's Name/Reletionship J. Thomas Routz				et and Number or Ru				)	
	20a. Method of Disposition			position (Name of	St., Mid			1769 City or Town, S	lata	
	1 ☑ Burial 2 ☐ Cremation 3 l	Removal from Stata	cematery, cri	ematory or other p						
	4 Donation 5 Other (Spec			in Cemete	2	12/29	Midale	town, M	D.	
any injury or once.	21. Signatura of Funeral Service Lice	Directe		22. Name and Add Donald B	Thompson	n Funeral	Home			
	X 20 1	) and will		3. E. Ma	in St., M	iddletown	, MD.	21769		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de one cause on each line.	ath. Do not e	nter the mode of d	lying, such as cardiac	or raspiratory arra	si,	Inten	oximata val Batween et and Death	
ian cal	Immediate Course (Final							Onse	and Death	
ner	Immediata Causa (Final diseasa or condition resulting in death)	· Sepsis						130	aus	
2		Due to	(or as a cons	equence of):					ays ays eral	
edical Examiner		6. Preumouis	1	and a				34	ay s	
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O C	(or as a cons	equence or):				Sev	eral	
edical	that initiated events	c. Cditt co	or as a conse	equence off:				mo	nths	
8	resulting in death) Last	Dua to	(or as a conse	squerice ory.						
S		d								
by Physician/Med	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying causa	given in Part I.	23b. Did to	bacco use cor	ntribute to the o	ause of death?	
hy			•			1 □ Ye	a 2 No	3 Probably	4 Unknown	
d be detached	Anemia, neutro	penia, rena	1 teul	we						
Completed						24a. Was an		available		
ple p								completi of death	on of causa?	
Page						1 ☐ Ya	s 2170No	1 ☐ Yas	2 No	
To Be C	25. Was casa refarred to medicat				26. Place of Dea	ith (Check only one	a)	1		
ToE	axaminer? 1 ☐ Yas 2 ØNo	Hospital: 1 Onpatient 2	☐ ER/Outpation	ent 3 DOA	Wher	lome 5 Raside		ar (Specify)		
	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury			28d. Describe ho				
Completely filled in by the funeral Medical Certification:	2 Accident investigation	on	in gory		☐ Yes 2☐No					
tiffe	3 ☐ Suicide 6 ☐ Could not lead to determine determined		home, ferm, s	street, factory, offic	>0	281. Location (Str. City or Town.	reet and Numb , Stata)	er or Rural Rou	ta Number,	
Ce			,							
edical	(Check only 2 Medical Exa	hysician: To the best of my icr miner: On the basis of axamir	nowledge, des	ath occurred at the	tima, data and place	, and due to tha ca	use(s) and me	nnar es stated. and due to the o	ause(s)	
	one)	and manner stated.								
Σ	29b, Eignature and Dile of certifier				ense number	29	1 1 1 1 1 1 1	d (Month, Day, 1	rear)	
	Jorden, M.	7			554705		12/25	199		
	30. Nama and address of person who	completed cause of death (Ite	em 23a) (Type	e, Print)	Freden	cle AAN	217	101		
	Kathenne Buc			Street	meden	VE /410	011	101		
State	31. Data filed (Month, Day Year)	9 1000 Signatura	naturo	4	1					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death December 25, 1999 **Physician** ELMER CLAY RICE 10:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner l Victor Drive Thurmont Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yrs. Director 76 220-16-0703 June 17, 1923 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 □ No Director Maryland Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 1 Victor Drive 21788 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. other than "natural", or ite 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 ie marked other that eny Injury or other traumatic event, ITem 2016s. 12 Electrician Moores Business Comm. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 86 Lewis S. Rice Annie E. Fultz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joan E. Andersen Rice (Wife) 1 Victor Drive, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burlal 2 Cramation 3 Removal from Slate
4 Donation 5 Other (Specify) Lewistown Cemetery 12/29/99 Lewistown, Maryland 21. Signature of Pune 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that news the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 980 signed by the a Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1□Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Panding a 24 hours after death.
Funeral Director: After the function of the function o 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i \* Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner; On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ifem 28a) (Type, Print) Cline III, 300 West Ninth Street, Frederick, Maryland 21701 Casper E. MD 31. Date filed (Month, Dey, Year) 32. Regisfar's Signature State DEC 2 8 1999

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 1999 20:30 31 Helen Grace Semler December /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Washington County Hospital Washington Hagerstown If Under 24 Hrs. 8 Date of Birth Month Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys Months 1 ☐ M 2 🕱 F Director 217-56-0462 February 27, 1907 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits must be notified at Maryland Washington tyE Yes 2 No Hagerstown Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 217 N. Cleveland Avenue 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 natural, or 1 ☐ Yes 2 € No Specify: Specify: White þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' ary or other treumatic event, ins Ma Elementary/Secondery (0-12) College (t-4or 5+) homemaker home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles Henry Fultz Mary Elizabeth Fultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) t9a. Informent's Name/Relationship (Type, Print) 217 N. Cleveland Avenue Hagerstown, Maryland 21740 of Disposition (Name of Date 20c. Location - City or Town, State Helen F. Birdsall Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department of Important: If any Injury or pace. Hagerstown, Maryland Cedar Lawn Memorial Park 1/4/00 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

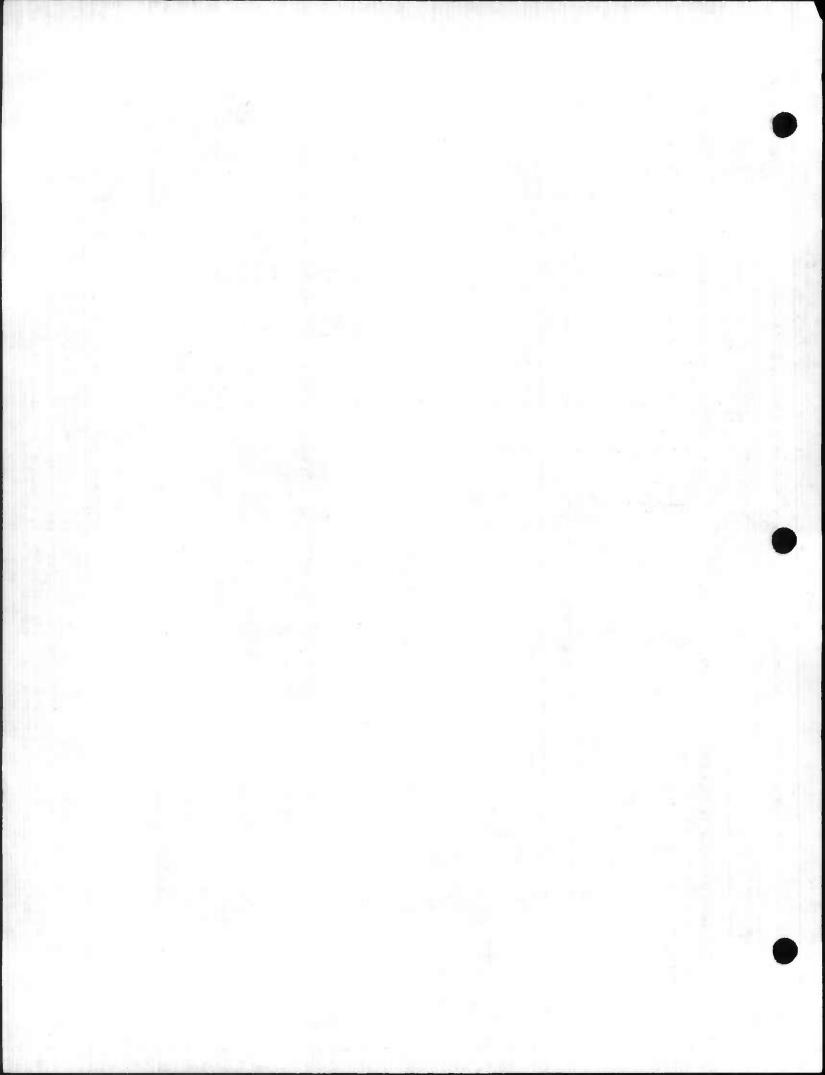
Approximate Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) physician s the buria P.O. Box 68760. Due to (or as e consequence of) when Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medicel axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month. Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital t Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUONSBURO & HAZA LA 2031 31. Date filed (Month, Day, Year) JAN 0 4 2000 32, Registrar's Signature State

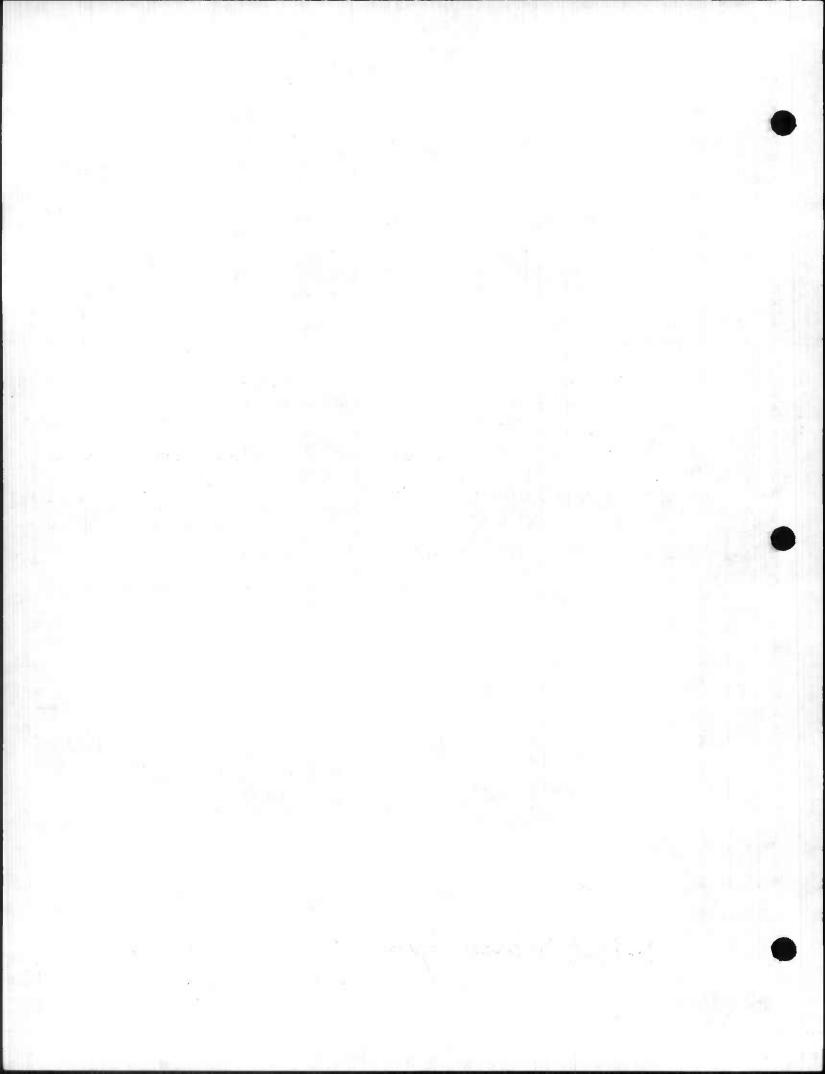
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 99 42659.

			Certificate of	Death	Re	ig. No.	16000							
811-1-	1. Decedant's Nama (First, Middla, Last)				2. Data of Deat Month	h Day Yaar	3. Tima of Death							
Physician /Medical	Louise Shipley S	utter			Dec. 2	9, 1999	2:00 P.							
Examiner	4a Facility Nama (If not institution, give street and number 8507 Mapleville Road	Apt. 11		lb. City, Town, or L Boonsbo		4c. County of Dec								
	-	Apt. II		If Under 24 Hrs.	8. Data of Birth	Washing	thplace (Stata or Foreign							
Funeral Director	- V-	The second second second	rs. Months Days	Hours Min.	June 22	, 1905 Ma	aryland							
fland as a	10a. Stata 10b. County	10c. City, Town	or Location				10d. Inside City Limits							
with the Marylan a or 28a-f show be notified at Director	Maryland Washington	Во	onsboro				1 ☐ Yas 2X No							
ath with I	10e. Street and Number 8507 Mapleville Road Apt	. 1103	10f. Zip Code 21713	3	10	10g. Citizen of What Country?  USA								
ors after de st', or Herre Examiner n	11. Marital Status  1 Nevar Married 2 Married  1 Nevar Married 2 Married  3 Widowed 4 Divorced  12. Was Deceda Armed Forca  1 Yas 28  1 Yas Gway Yaar or Dete	s? No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yas 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, atc.)	14. Race - Am Black, Wh Specify:								
ed within 72 ho ogsiens. er then "nefum 4, the Medical.3	15. Decedant's Education (Specify only highast grada completed)	16a. [	Decedent's Usual Occup Giva kind of work done life. DO NOT use retired	ation during most of work	ing	16b. Kind of Business	s/Industry							
within then then then	Elementary/Secondary (0-12) College (1-4c	or 5+)	life. DO NOT use retired Lf Employed	1)		seauty Sho	n							
Hied Hygie Bher C	17. Father's Nama (First, Middla, Last)	50.	ii impioyed	18. Mothar's Nam	a (First, Middle, Maiden Surnama)									
fortal H fortal H fortal H for ever	John Henry Sutter			Oda Loui	se Shipl	ey								
2 shot	19a. Informant's Name/Ralationship (Type, Print)	19b.	Mailing Address (Street	and Number or Rui	al Routa Number,	City or Town, Stete,	Zip Code)							
. 도등하는	Karen D. Kiley Trust O		W. Washing	ton Street			ryland 21740							
simit. Pages 1 department of He reportant: If her my injury or oth files.	20a. Mathod of Disposition  1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cematary, cramatory or other place) Rose Hill Cemetery  1/3/00 Hagerstown,													
permit. Depart Imports any Inji	21. Signiture of Funeral Sarvice Licensee  22. Name and Addrass of Facility  Gerald N. Minnich 305 N. Potomac Street  Funeral Home Hagerstown, Maryland 2174  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed tha daath. Do no	ot enter the mode of dyir	ne. ng, such as cardiac	or respiratory arre	own, Mary	Approximata Interval Between							
Physician				C :			Onset and Death							
/Medical Examiner	Immediate Causa (Final disaasa or condition rasulting in death)	gestive	e heart	tallu	re		lyear							
		Due to (or es e co	onsequence of):		blas .	disame	15 10000							
executed n and iel-trensit Examiner	b. ar ter			mary u	ittery	AISOISC	15 years							
cate be executed physician and s the burial-trensit														
Ping N	that initiated evants resulting in death) Last	Dua to (or as a co	ensequance of):											
the property of		_												
D 9 8	Part II. Other significant conditions contributing to death	23b. Did tobacco use contribute to the cause												
- 60 -					10 11	ns 210416 3□1	Probably 4 Unknown							
requii					24a. Was a perform		. Were autopsy findings available prior to completion of cause of death?							
The lew ate has page 2					1 □ Ya	s 20 No	1 ☐ Yas 2 ☐ No							
defan: The certificate rector, pag	25. Was casa rafarred to medical			26. Place of Deel	h (Check only on									
Physician: this certific ral director,	axaminar? 1 ☐ Yas 2 ☐ No Hospital: 1 ☐ Inpa	ntient 2 ER/Outp	patient 3 DOA Oth	er: 4 Nursing Ho	ma 5 Raside	nce 6 Other (Sp	ecify)							
After fune	27. Mannar of Death 1 DNatural 5 Panding (Month, L	njury 28b. Ti Day Year) Inj	jury Wor	yat k? Yas 2 ⊡No	28d. Describe ho	w injury occurred								
To the Hospital or Attending P within 24 hours effer death to the Funeral Director. After the completely filled in by the funeral Medical Certification:		Injury - At homa, farr atc. (Specify)	m, atreet, factory, office		28f. Location (St City or Town		and Number or Rural Routa Number, ata)							
To the Hospital or All within 24 hours eiter of To the Funeral Direct completely filled in by Medical Certiff	29a. Certifiar (Check only one)  1 Certifying Physician: To the besidence on the property of t													
within To th comp	29b. Signatura and title of certifiar	1 1	29c. Licens	e number	2	9d. Data signed (Mor	nth, Day, Year)							
	Value Brell MD Hersonal Physician DO4359 01/11/20													
	30. Name and address of person who completed cause of Robert Brull M.D.	1 death (Item 2) (T	ype, Print)	Ave.	tagers	stown, r	MD 21742							
State		strar's Signatura	6 1		100	VI VI								
Registrar	JAN 1 0 2000	neva /	. spark	2/										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Day Month Physician 9:00 pm Palmer Rodney Schlegel December 20, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 708 Clayton Street Aberdeen Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Days Months Hours 1€M 2□ F Yrs. 68 Director Apr. 24, 1931 Pennsylvania 186-28-5142 the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits TR 23a or 28a-f show 1 XYes 2 □ No Director MD Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 708 Clayton Street 21001 21001 Funeral death r than "natural", or items to Modical Examples in 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Tyes 2 No
If Yes, Give
Year or Dates: 1953-55 1 ☐ Never Merried 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Mathematician 5+ U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Schlegel Ruth Faye Troutman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Mrs. Marian A. Schlegel (Wife) 708 Clayton Street, Aberdeen, Maryland 21001 or other 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removei from State 4 Donation 5 Other (Specify) Depertment of Important: If R. A. Ferris & Co., Inc. 12/22/99 West Chester, PA 22. Name end Address of Fecility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funger Service Licensee Aberdeen, Maryland 21001-3399 me death. Do not enter the mode of dying, such es cardiac or respiratory arrest, 23a. Pert1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final zare disease or condition resulting in death) **Examiner** Examiner physician and the burief-trensit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760 Physician/Medical the Due to (or es a consequence of) 98 USB jo signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings evailable prior to Completed 24a. Wes en autopsy performed? peed completion of cause of death? hes pede 2 1 Yes 2 No 1 TYes 2 No certificete director. 25. Was case referred to medical Be 26. Piece of Death (Check pnly one) examiner? Other: 4 Nursing Home Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 Residence 6 Other (Specify) this funerel 28c. Injury at Work? 27. Manner of Death 28e. Dete of injury (Month, Day Year) 28d. Pescribe how Injury occurred 28b. Time of Certification: After 5 Pending investigation Injury 1 Natural 1 Yes 2 No **2** ☐ Accident Hospital or Attend
 24 hours after deeth
 Funeral Director: / 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, end due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 To the I 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 29c License number

State Registrar 30. Nem

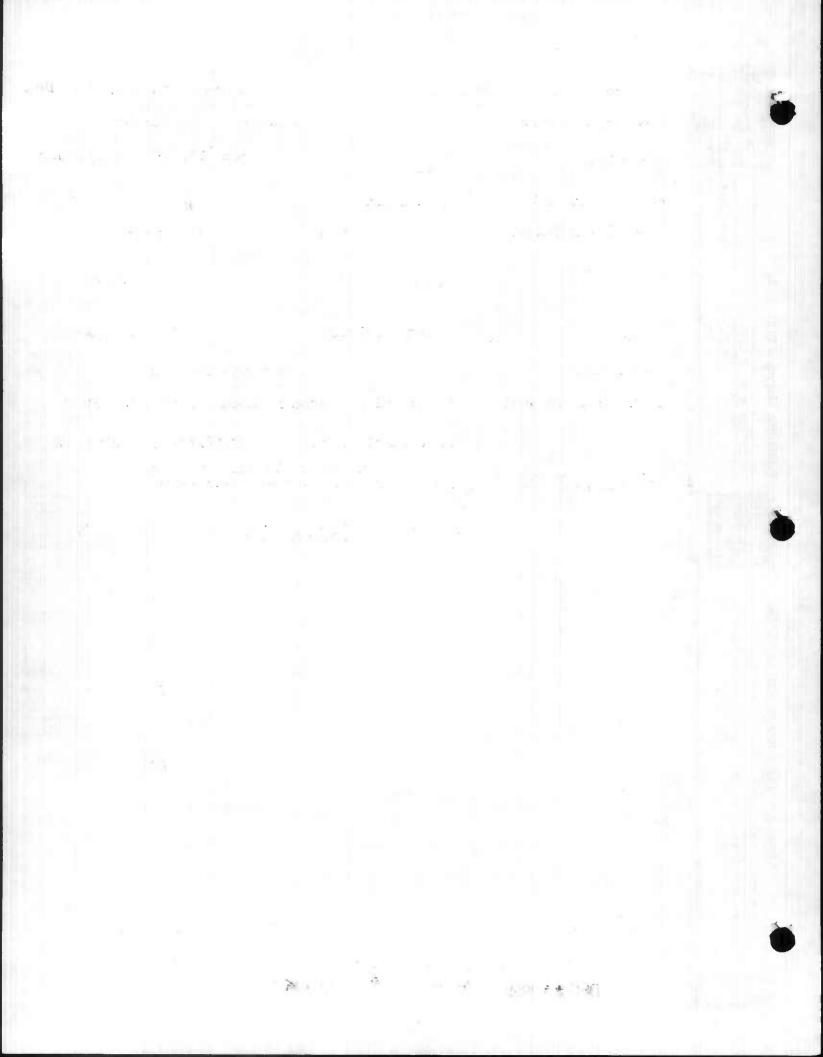
in and a

31. Date filed (Month, Day

iddress of person who completed cause of deeth (Item 23e) (Type, Print)

r's Signature

no



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (2)

					State of	waryiar		tificate of	Death	Mental Hy	Reg. No.	9 4	2661
	Dhunia		1. Decedent's Name (Fir.	st, Middle, La	rst)					2. Data of De	eath Day	Year	3. Time of Death
4	Physici /Media		EL	EANOR		COCH	RAN	SIX		Dec.	0.00	999	11:40 AM
	Examir		4a. Facility Name (If not I	nstitution, gi	e street and numi	ber)			4b. City, Town, or	r Location of Deat	h 4c. Cour	ity of Death	
			2019 Pl			Road				llston		Harf	
1	Funeral		5. Social Sacurity Number		Sax 7 1 □ M 2 10 F		last birthdey) Yrs.	Months Days		. (Menth. Di	th ay, Year)	9. Birthp	place (Stata or Foreign
	Director		218-40-858 Usual Rasidance of Dece			85	115.	-		5/1/-	1914	Mai	ryland
	land			County		10c. Cit	y, Town or Loc	ation				1	0d. inside City Limits
	Marylan f show	0	MD.	Har	ford				Falls	ton			1 ☐ Yes 2 No
	with the Marylar a or 28a-f show be notified at	Director	10e. Street and Number					10f. Zip Code	2 00220	1012	10g. Citizen o	f What Cour	ntry?
	72 hours after death with the Maryland netural; or items 23s or 28s-f show dics! Examiner must be notified at		2019	Plea	santvil	lle R	nad	0	21047			U.S.A	
	for death v froms 23a	Funerai	11. Marital Status	11.00	12. Was Daced	ant Ever in U		as Decedant of I	Hispanic Origin? ( ean, Maxican, Pue	Specify Yas or No		ace - Americ	an Indian,
0	or the	F	1 Never Married	Married	Armed Ford	M No				rto Rican, etc.)	В	lack, White,	etc.
02	al', o	by	3 ☐ Widowed 4 ☐ [	Divorced	If Yes, Give Year or Dat	as:	1	☐ Yas 2 No	Specify:		Spec	eity: Cal	icasian
5-0	72 hours "natural",	Be Completed	15. E	ecedent's E	ducation ade complated)		16a. Deced	ent'a Usual Occup	pation during most of we	orkina	16b. Kind of	Business/Inc	duatry
21	within lene. then "	npie	Elementary/Secondary		College (1-4	lor 5+)	lifa. D			Orking			
2		Cor	8			-		House				Home	
PL	be filed ntel Hygi od other event, t		17. Father's Name (First,		)					ame (First, Middle			
Yla	should be and marked of umetic eve	70	Anth				Cochra			atherin			tephens
Maryland 21215-0020			19a. Intormant's Name/F						t end Number or F		er, City or Tow	m, Stete, Zip	Code)
	l and lealt im 27		Robert M. 20a. Method of Disposition		/Husbar			1e as #	10 a, b		20- 1	Ohren	21-1
Jor	If he or o		Burial 2 □ Cre	mation 3			ematary, crem	etory or other ple	ice)	12/30	20c. Location		
Baltimore,	t. Partmer		4 □ Donation 5 □0		**	St		i's Cem		1999	Hydes	, Mai	ryland
Bal	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra 90ce.		21. Signature of Funeral	Sarvice Lice	nsee )	14	22.	Name and Addre	urtz &	Son Fu	neral	Home	P.A.
	TD = 4 G		111.	Mode	len Tu	MAI	1	Jarret	tsvill	e, Mary	rland		,
			23a. Part1. Enter the dis shock, or heart failu	ease, or com	plications that cau	ch line.	h. Do not anta	r tha moda of dyi	ng, such as cardle	ac or raspiratory a	irrest,	1	Approximata Interval Batween
	Physician					-1	1.7					i	Onset and Death
4	/Medical Examiner		Immediate Causa (Final disaase or condition rasulting in death)		a	TIC	oke					/	month
п		_	rasuling in coalin			Due to (d	or as a consequ	ience of):				1	
	pe jist	nin			b. ————							1	
	ficete be executed physician and is the burial-transit	Examiner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Causa (Disease or Injury	ata		Due to (c	r as a consequ	ance ot):				i	
60	siciar buria		cause. Enter Underlying Causa (Disease or Injury that initiated evants	~	c							i	
68760,		edical	resulting in death) Last			Dua to (o	r as a consequ	ence ot):				f I	
Box	stending for use a	2		-	d								
ä	stte d for	cia	Part II. Other significant	an ditions	and the single and so the si	h hut and and		202-311 III IV IX	and Didd	00h DId	A-b	1	
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rds	requires heen sign hould be	8 0	0.	15	11					24a. Was	an autopsy	24b. W	ere autopsy findings
8	_ 40 00	Set	- Len	4 1	allure					pen	ormed?	CO	allable prior to mpletion of cause death?
R	0 - 2	Completed								10	Yas 2 No		Yes 2 No
Division of Vital Records,	iclan: The certificate rector, pag	BeC	25. Was case reterred to	medical					28 Place of De	eath (Check only			1 7 es 2 🗆 140
>	Physician: this certific ral director,	To B	examiner?		Hospital: 1 ☐ Ing	atlant 2 🗆	ER/Outpatient	3□ DOA Ott	her: 4 Nursing	14	dence 8 🗆 C	ther (Specif	w)
0	g Phys er this neral di		27. Manner of Death		28a. Date of (Month,		28b. Time of	28c. Inju Wo		28d. Describe			,,
0	Attanding or death.  Setor: After by the fune	atio	1 Natural 5 ☐ 2 ☐ Accident	Pending investigatio		Dey rear)	Injury		Yes 2 No				
vis	er de ecto by tr	tific	3 ☐ Sulcide 6 ☐ 4 ☐ Homicide	Could not be detarmined	286. Place of	Injury - At he	oma, tarm, stre	et, tactory, office		28t. Location (	Street end Nur wn, State)	nber or Rura	I Route Number,
Ö	tal or A	Certification:			Dullulig	, etc. (opecii	,			Ony or 10	wii, Otatoj		
	To the Hospital or Attanding Physician: within 24 hours effected. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edicai	29a. Cartifier (Check only	ertifying Ph	ysician: To the basi	est of my kno	wiedge, death	occurred at the ti	ma, data and place	e, and dua to the	cause(s) and	manner as s	ated.
	the H in 24 the F	8	ura)		and manna	r stated.	HON MICON INV	ssugation, in my t	opinion, daam occ	curred at the time,	date and place	e, and due to	the cause(s)
	o t with	Σ	29b. Signatura and title of	certifiar	00			29c. Licens	se number	-11	29d. Data sign	ned (Month,	Day, Year)
	/		► Will	ard	Y. (N	MOS	り	100	6400	57 1	Jecer	nber	21, 1999
	6		30. Name and address of	person who	completed causa	ot daath (Iten	23a) (Type, F	Print) 0 /	1.1	) [	-11+	. 1	M / Diagra
			Willord	15 /	1 mos	5	730	y Del	Must	load t	ollsh	on, I	10. 21041
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State of Maryland / Department of Health and Mental Hygiene 99 42662

			C	ertificate o	t Death		Reg. No.				
	1. Decedent's Nama (First, Middle,	Last)				2. Date of D			3. Tima of Death		
Physician	Hamald De	lawa Gi				Decemi Decemi	Day	1999	5:45 P.M		
/Medical	4a Facility Name (If not institution,	lano Stace	У		4b. City, Town	n, or Location of Dec			Jian Pall		
Examiner	The state of the s					rdeen		arford			
	1112 North Ste		Marine In a block of	(v) If Undar 1 Ye							
Funeral Director	5. Social Sacurity Number 223-42-2815	Sex 7. Agr	63 (In yrs. last birthda	Months Day		Min. (Month, L	Day, Year) 2, 1936	Virgi	ca (State or Foreign y) nia		
natural', or itema 23e or 28e-f show acel Examiner must be notified at sted by Funeral Director	Usual Residence of Dacedent										
show det	10a. State 10b. County		10c. City, Town or	Location				100	d. Inside City Limits  1 ☐ Yes 2 (X)No		
or 28a-f s be notified		ford	Aberde								
or 2	10e. Street and Number			10f. Zip Code	•		10g. Citizen of	What Country	y?		
23e	1112 North Step	ney Road		2100	1		USA				
w terms 23s other must Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever In U,S. 1:	3. Was Decedent of	f Hispanic Origin	n? (Spacify Yas or P Puerto Rican, etc.)	No- 14. Ra	ca - Americar			
Examiner must be notified at Examiner must be notified at by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced			1 ☐ Yes 2½ N		Paerto Filoan, etc.)	Specil				
er than "natural", o r, tra Medical Exar Completed by	15. Decedent's (Specify only highest	Education orade completed)	16a. De	cedent's Usual Occive kind of work do	cupation ne during most o	of working	16b. Kind of B	Business/Indu	stry		
item 27 is marked other than "natur other traumatic svent, the Medical To Be Completed	Eiementary/Secondary (0-12)	College (1-4or 5	+)	ve kind of work doi . DO NOT usa ret		ce Supervisor Shoe Manufacturer					
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Be ver	17. Father's Name (First, Middle, La	i de la composition della comp									
marked other imatic svent, I To Be Co		Stacey				ie Belle					
is meraner	19a. Informant's Name/Relationship					or Rural Route Num d., Bel A			Code)		
r other tra	Harold D. Stacey	, Jr. / Sc			viite k		1				
	20a. Method of Disposition  5GBuriai 2 ☐ Cramation 3	□Pamoval from State	20b. Place of Dis cematery, o	sposition (Neme of rematory or other p	olace)	Dete	20c. Location	- City or Tow	n, Stata		
2	4 Donation 5 Other (Spe		Harford	Memoria	1 Garde	ns 12-30-	99 Aldir	o, Mar	ryland		
important: If any injury or once.	21. Signatury of Funeral Service Lie	ensee		22. Name and Add	ress of Facility	l Home, P	7				
any ir	D 26000 V		010	200							
	THE PARTY C.	Momas	The death December			Road, Ab			DDPOximate		
	23a. Part1. Enter the disease, or conshock, or heart failure. List or	rly one cause on each lir	the death. Do not the.	enter the mode of c	lying, such as ca	ardiac or respiratory	arrest,	. 1	nterval Batween Onset and Death		
sician								1	oriset and Death		
edical miner	immediate Cause (Final diseasa or condition	CON	6 = 97	H SU	EART	FAIL	VRE	1			
	resulting in death)	α.	Due to (or as a con:	sequence of):		FAIL		1			
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iel-transit Examiner	Sequentially list conditions	b	Due to (or as a cons	sequenca of):							
es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury							i			
edical	Ceuse (Diseese or injury that Initiated events	C	2								
1 D	resulting In death) Last		Due to (or as a cons	sequence of):							
8 5		d						i			
2 5								I			
hedi	Part II. Other eignificant conditions	contributing to death be	it not resulting in the	underlying cause	givan in Part i.	23b. DI	d tobacco use co	ontribute to t	he cause of death?		
F 8.9						1[	Yee 2 No	3 Proba	bly 4MUnknow		
p g											
should should leted							as an autopsy rlormed?		e autopsy findings leble prior to		
pe 2 shoul						pe		com	pletion of cause eath?		
page 2 should							Two office				
rector, page						11	Yas 2 No	10	Yas 2 No		
director,	25. Was case referred to medical examiner?	I to a shall				of Death (Check only	y one)				
P 0	1  Yes 2 No	Hospital:		tient 3 DOA	Other: 4 Nurs	sing Home 5 Re	sidence 6 Ot	her (Specify)			
	27. Manner of Death	28a. Date of Inju (Month, Day	y 28b. Time	of 28c. Ir	njury at Vork?	28d. Describ	e how Injury occu	rred			
in by the funeral	1 2 Naturai 5 ☐ Pending 2 ☐ Accident investige		injur		Yes 2 N	0					
# the	3 ☐ Suicide 6 ☐ Could no	200. Placa of Inju	iry - At home, farm,	street, factory, offic	De .		(Street and Num	ber or Rural	Route Number,		
ed in by the funera Certification:	4 Homicide	building, etc	. (Specify)	,		City or 7	own, Stete)				
	29a. Certifier 1 ☐ Certifying	Physician: To the heat	f my knowledge de	eth occurred at the	time date and	nlace and due to the	e causals) and ~	enner es ete	ted		
edicai	(Check only 2 Medical Ex	Physician: To the best of aminar: On the basis of	examination and/or	investigation, in m	y opinion, deeth	occurred at the tim	e, date and plece	, and due to t	he ceuse(s)		
Med Med	one)	and manner sta	teo.	200 110	ance number		20d Data sign	ed (Month D	ev Vest		
completely litted	29b. Signature and title of certifie	. 1			ense number	_	29d. Date sign	eu (Moritin, D	cy, roat)		
	Munch	mh	D M	E 0	OM	=	Dec .	2619	99		
	30. Name and address of person with	o completed cause of d	eth (Item 23a) (Tvr				-				
0	1 D.	Completed cause of di		Anti- Ac	2 4 4	MA O	21011				

State

Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Q Q

			Otato C	i wai yiai			e of Dea		Rec	a. No.	1 4	2663	
			Decedent's Name (First, Middle, Last)						2. Deta of Deeth			3. Time of Death	
	Physici		Clifford Andrew	Smith					Month	Dey 1	Yaer	0.47 DM	
N	/Medic		4a. Facility Neme (If not Institution, giva street and nu				4b. Cit		December cation of Deeth	27, 1		9:47 PM	
A. S.	Examir	ner	Good Samaritan Hospital		Sec Iv	Tna		altimor		401 County			
-			5. Social Security Number 6. Sex	7. Aga (In yrs.	4			nder 24 Hrs.			0 Bishol	an (Ctata as Fasain	
н	Funeral Director		526-54-3204 1™ 2□ F	66	Yrs.	Months		ours Min.	8. Date of Birth (Month, Dey, )			ace (Stete or Foreign ry)	7
			Usual Residence of Decedent						April 10	, 1935	ACK	ansas	
	dan ow		10a. Stete 10b. County	10c. Cit	y, Town or L	ocation					10	d. Insida City Limits	
	Man	ō	Maryland Harford			Edae	ewood					1 ☐ Yas 2 🔀 No	)
	the 128s	rec	10e. Street end Number			10f. Zip			100	g. Citizen of V	Vhat Count	rv?	-
	Nith Sa on	Funeral Director	2407 Sycamore Lane				21040	n		USA			
	ne 2	era		edant Evar in U	S. 13.	Was Deced			cify Yas or No-		e - America	n Indian.	-
	Her	-un		rces? 2 No 195	1 -	if Yas, speci	ify Cuban, Ma	xican, Puarto	cify Yas or No- Rican, etc.)		k, White, a		
21215-0020	within 72 hours after death with the Maryland iene. Than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at	by i	If Yas, Gir 3 Mg Widowed 4 □ Divorced Yeer or D	/e etes: 197	1	1□ Yes 2	2⊠No Spe	ecify:		Specify	Whi	te	
Ö	hou		15. Decedant's Education		18e Dece	dent's Usue	I Occupation		16	6b. Kind ot Bu			
15	on Ta	Completed	(Specify only highest grade completed)		(Give	kind of wor	rk done during se retired)	most of worki	ng	JO. 11110 O. D.		20119	
12	with the constitution	E C	Elementery/Secondary (0-12) Coilege (	1-4or 5+)		ilita				IIG	Cover	nment	
P	한 보고		17. Father's Nama (First, Middle, Last)		1.1	LILCU	-	Mother's Neme	(First, Middle, Me			THEATC	-
Maryland	S d la D	o Be	George (u/k) Smith				Ta	aura (	u/k) Mc	Cormic	de		
2	d 2 should but and Menta the and Menta T Is marked traumatic even	To	19e. Intorment's Neme/Relationship (Type, Print)		19h Mail	ing Address			l Route Number, (			nde)	-
Ma	D = 1 = 0											3000)	
0	is 1 and 2 of Health item 27 I		Barbara O'Neil - Daughte		Plece of Disp			Bel Air	, Maryla	Dc. Location -	.014	m State	-
0	Pages nent of H rrt: If ite iry or of		1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from	Stata	ematary, cra	metory or of	ther piece)						
ţ	tmer tant		4 Donetion 5 Other (Specify)	Hi			ce Corp		2-30-99	Towso	n, Ma	ryland	
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21 Sorutura of Funaral Service Licensee		84	ia Como	d Address of F	cal How	e, P.A.				
_	00 = 0		Alla K. WHome	h_	1	317 C	okeshu	ry Rd.	Abingdo	n. Mar	vland	21009	
			23a. Partt. Enter the tilsease, or complications that o shock, or heart hitiure. List only one cause on e	aused tha deet	h. Do not en	ter the mode	e of dying, suc	ch es cerdiec o	r respiratory arres	it,	yacare	Approximate Interval Between	Т
N	Physician		/									Onset and Deeth	
ч	/Medical		tmmediate Cause (Finel disease or condition	NTH	CUL	AR	- AX	2/2/4 <sub>7</sub>	THM	11	3	) min	
н	Examiner		resulting in deeth)		r es e conse	SAPERINE.							-
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68760,	te be	Physician/Medical	Cause (Diseese or injury that initiated events	Due to (o	r es e conse	quence of):							-
89	E 0 6	Pe	resulting In deeth) Last			,					į		
Box		5	d					_					_
m	d for	Cia	Part II. Other afgniffcant conditions contributing to de	ath but not rec	uiting in the	indodvina os	auca chica in I	Dort I	22h Did toh	8000 H88 00F	stellbute to	the cause of death	2
0	that the de ed by the a detached	hys	201		_		ausa givon iii i	roiti.	1 Yes	./		ably 4 □ Unknow	
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Ö	v require been sig should t	Completed							performe		con	leble prior to pletion of causa	
36	hes pe 2	ם									of d	eeth?	
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Vital	Physician: The ribis certificate ral director, pag	Be	25. Wes case reterred to medical exeminer?	100				Plece of Deeth	(Check only one)	)			
of	0 0	ို			ER/Outpatie		_		ne 5 🗆 Residen	-			
<u>_</u>	ding P. After funer	.HO	27. Menner of Deeth 1 Netural 5 Pending (Mon.	th, Dey Year)	28b. Tima o Injury		8c. Injury at Work?		28d. Describe how	injury occurr	ed		
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation			М	1 Yas	2 🗆 No					
Division	or Attendation of the or Attendation of the order of the order of the order of the order of the order of the order of the order order of the order of the order order order order order order order order order order order or	Certification:	determined 288. Plece	ot fnjury - At ho		reet, fectory,	, office	1	281. Location (Stre City or Town,	et and Numb Stete)	er or Rural	Route Number,	
	tal or al Dir led in	ပိ											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29e. Certifier Check only Magnetal Exampler: On the bi	best of my kno	wiedge, deet	h occurred e	ot the time, de	te end plece, e	and due to the ceu	se(s) end ma	nnar as sta	ited.	
	the h in 24		one) and men	nar stated.			my opinion	, 300(1) 0000111	- at the time, uet	- uno piace, t			
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			quen	- /1	11/	E	083	$\varphi\varphi$		12/2	7/99	3	
	1241		30. Name and address of person who completed ceus	e ot deeth (Item	23a) (Type,	Print)	- /	,		1			
	10 11		Luis E. Rivera, 5714 H				imore.	Maryla	nd 21214				
	Sta	te		egistrar's Signa		4		7.5				У	
	Registr	-	DEC 9 0 1000	Denes		47.	1000 1	61					

# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of l	Death	R	eg. No.	42664
	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	th Day Yea	3. Time of Death
Physician /Medical	James	Melvin	Sk	elley			DECEMB		
Examiner	4a Facility Name (If not institution,	nive street and number)			1	lb. City, Town, or	Location of Death	4c. County of De	
	Brant Road (1	P.O. Box 528	31)		F	Cresap			llegany
neral ector	216-09-3440	Sex 7. Age (In )		rs. If Und Months	er 1 Year s Days	If Under 24 Hr. Hours Mir		9. E 3, 1911	Sirthplace (State or Foreign Country) MD
_	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town	or Location					t0d. Inside City Limits
over must be notices as funeral Director	MD A1:	logany		Cxoco	nt ou	7			1 ☐Yes 2 ☐ No
Director	10e. Street and Number	legany		Cresa	D Code	П		0g. Citizen of What (	A
ral Di	Brant Road (1		,			2150	2	USA	
by Funeral	11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1	n U,S.		edent of Hi ecity Cuba 2 No	ispanic Origin? ( nn, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, WI	nerican Indian, hite, etc. hite
Completed	15. Decedent's (Specify only highest)	Education erade completed)	16a.	Decedent's Us	vork done o	durina most of w	orkina	16b. Kind of Busines	ss/Industry
di di	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired	0			
00	12		Не	avy M	achi	ne Ope		Construc	tion
e	17. Father's Name (First, Middle, La	st)					ame (First, Middle,		
2	John Skelley					Lotti	•	ilcott)	
	19e. Informent's Neme/Reletionship Bonnie L. Hol							tehouse,	TX 75791
	20a Welthough Disposition	Control of the Contro	. Place of cemeters	Disposition (No. crematory or	eme of other plec	<b>(a)</b>	Date	20c. Location - City	or Town, Stete
	4 □ Donation 5 □ Other (Spe	nifu)	St. A	mhros	0 00	motory	1/03/	Cresapt	own MD
st	21. Signature of Funeral Service Lic		N)	22 Name	and Addres	se of Facility, To	eral Hor	ne P A	OWIT, MD
9	1 din halp	1 MARON	111:				aryland	21502	
	23a. Pert1. Enter the disease, or conshock, or heart feilure. List on	replications that caused the d	eath. Do n						Approximete
n	shock, or heart feilure. List on	ly one cause on each line.							Approximate Interval Between Onset and Death
	Immediete Cause (Final	Ma lan	1.1			0.			1
	disease or condition resulting in death)	a. /1/27/131	1977C		ing	ma	er		142
6		Due to	o (or as a c	onsequence of	K./				
Examiner		b							1
EXa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a c	onsequence of	):				1
	Cause (Disease or injury that initiated events	C							1
edicai	resulting in death) Last	Due to	(or as a co	onsequence of	):				
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Cia							1 -54 -44		
Physician/	Pert II. Other significant conditions	contributing to death but not	resulting in	the underlying	cause give	en in Pert t.			rte to the cause of death?
							101	es 2 No 3	Probably 4 Unknown
Completed by							24a. Wes a perfor		b. Were autopsy findings available prior to completion of cause
E D									of death?
								es 2 No	1 ☐ Yes 2 ☐ No
e e	25. Was case referred to medical examiner?	Hospitel:	****		Oth		eeth (Check only or	10)	
5	1 Yes 2 No	1 Inpatient 2	□ ER/Out		JUA	4 LI Nursing	Home 5 Presid		pecify)
on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Ti	jury	28c. Injun Worl		28d. Describe h	ow injury occurred	
Certification:	2 Accident investigat 3 Suicide 6 Could not			М	10	Yes 2 □ No			
E	4 Homicide determine	28e. Plece of Injury - A building, etc. (Spe	t home, fan <i>cify)</i>	m, street, fecto	ory, office		28f. Location (S City or Tow		Rural Route Number,
edical	29a. Certifier 12 Certifying I	Physician: To the best of my interminer: On the basis of exam	nowledge,	death occurre	d at the tim	ne, date and place	e, end due to the c	ause(s) and menner	as stated.
8	one)	and manner stated.							
Σ	29b. Signature and title of eguifies	/		2	9c. Licenso	e number	. 2	9d. Date signed (Mo	onth, Day, Year)
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	30. Name and address of person wh					70.10		- CINB	1
	Gary Wagoner				Driv	e Cumb	erland 1	MD 21502	
State	31. Date filed (Month, Day, Year) JAN 0 7 2000	32. Registrar's Si		1					
ictror	JAN U 7 2000	Benevy B	1	no K	/				

person to sparie

mgs 7 6 WAL

State of Maryland / Department of Health and Mental Hygiene 99 42665 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 31, 1999 **Physician** RAYMOND LESTER STONE 1930 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Retirement Home Frederick Frederick If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 214-10-3431 Director 87 Oct. 23, 1912 Maryland Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 must be Berns 23s 990 Waterford Drive 21702 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status i fled within 72 hours after di if Hyglens. other than "natural", or flam Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Counterman & Salesman Automotive Parts Store permit. Pages 1 and 2 should be filled Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, \$2 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Harry G. Stone Carrie E. Brandenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Stone (Daughter) 6920 Sundays Lane, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation Mount Olivet Cemetery 1/4/2000 Frederick, Maryland 21. Signature of Fune 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701
Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approxim Approximate Intervel Between Onset and Death e, or complications that during List only one cause in mach **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medicai Due to (or as a consequence of) 88 980 P.O. signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 2 N No 3 Probably 4 Unknown Records. þ or Attending Physician: The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificate Division of Vital director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerai Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 28b. Time of Affler Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and Jim of Certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who comple

Street

300 W. 9th

31. Date filed (Month, Day, Yes

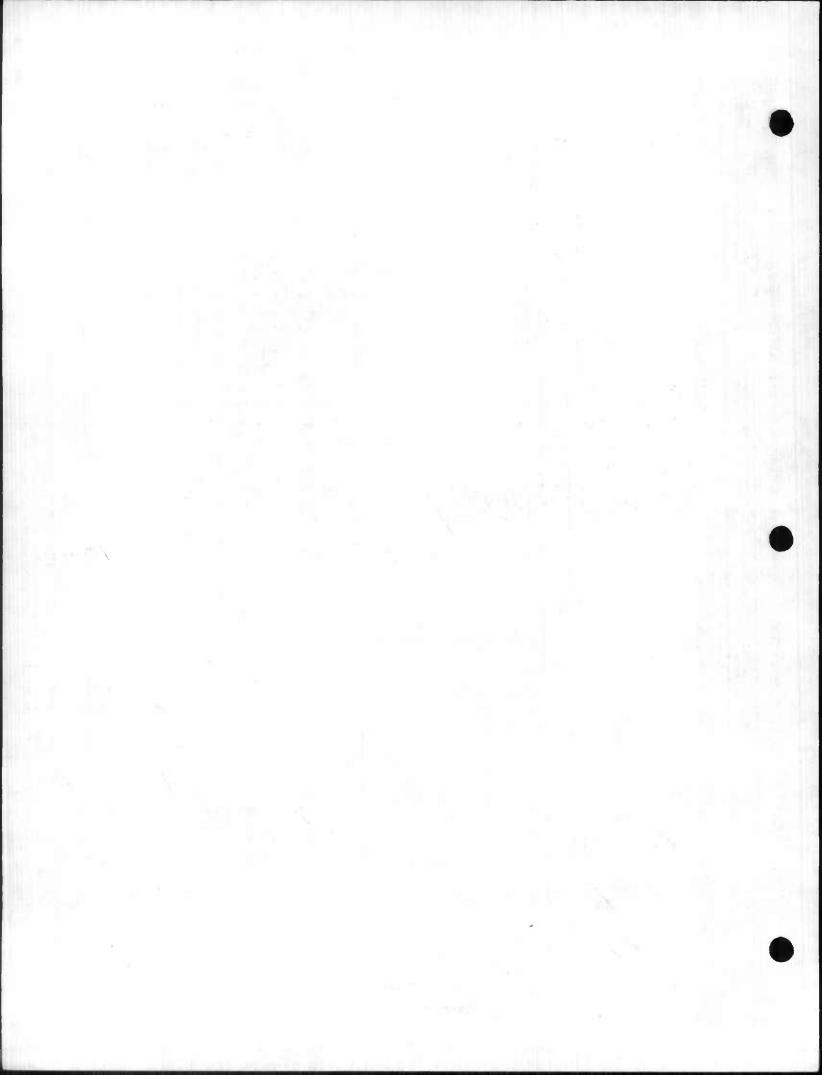
use of death (Item 23a) (Type, Print)

mD

32. Registrar's Signature

Fred.

4 2000



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 31, 1999 **Physician** 7:09 PM Emma Mae Simpson /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. 8. Date of Birth Nov. 15, 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Min. Maryland 1 M 2 TF Months Hours 214-28-5692 66 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Frederick Frederick Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21701 21 West All Saints Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

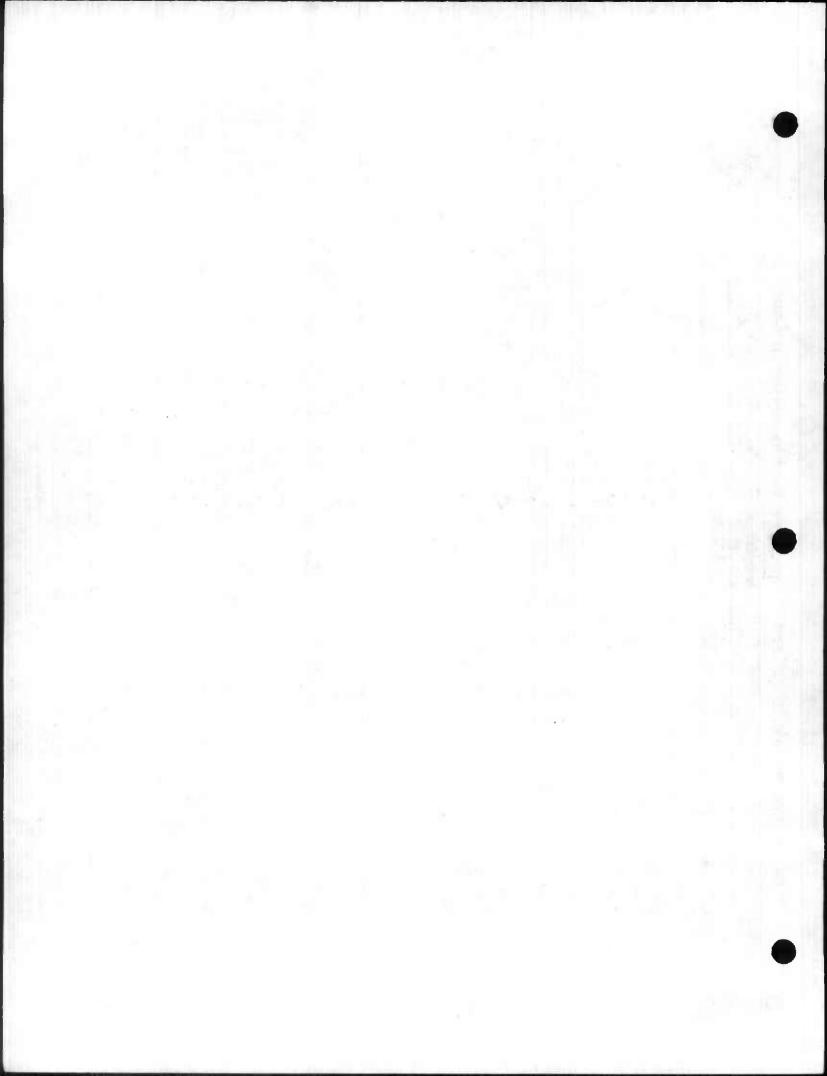
1 Yes 2 XXX

If Yes, Give
Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Europeans. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XX Specify: Specify: White þ 3 Widowed 4 Kill ivorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosa Anna Mae Haines George Washington Cleveland Shane 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
21 West All Saints St., Frederick, Md. 21701 19a. Informant's Name/Relationship (Type, Print)
Mr. Stanley R. Shane, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremetion 3 ☐ Removal from State Smithsburg Crematory, Jan. 3, 2000 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARDIAC ARREST minutes Examiner Examiner ATHEROSCUEROSIS physician and s the buriai-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): P.O. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Amerosyerosis Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Peripheral Vascular disease Encephalo malais,

25. Wes case referred to medical examine? 1 ☐ Yes 2 ☐ No Scizures 8 26. Placa of Death (Check only one) PMH Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HM6 edical Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Humain. 1)46861 1/3/00 Naaz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WM2- 月 サビジのト・ハゴ 195. T.J Drive Frederick MD 21702 31. Date filed (Month, Day, Year) 32 Re JAN 0 4 2000 32. Registrur's Signature State Registrar

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Day **Physician** Daniel David Snook 9:18 P.M. December 29, 1999 cation of Death | 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** VOM 20 F Days Months 217-32-5744 76 Director March 15,1923 Maryland Usual Residence of Deceden 10b Count 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other than "natural", or hama 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Frederick Thurmont Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21788 6134 Mountaindale Road United States deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. e filed within 72 hours after of Hyglene.
Other than "naturel", or her 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baitlmore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Feed supply, hardware Store proprietor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If them 27 is marked other
eny injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Webster Snook Mary Margaret Fawcett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6134 Mountaindale Rd./ Thurmont, Maryland 21788 Clara Elizabeth Snook/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11-3-2000 Frederick, Maryland Resthaven Mem. Gardens 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician and for use as the buriel-transit The lew requires that the deeth certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of): 88 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

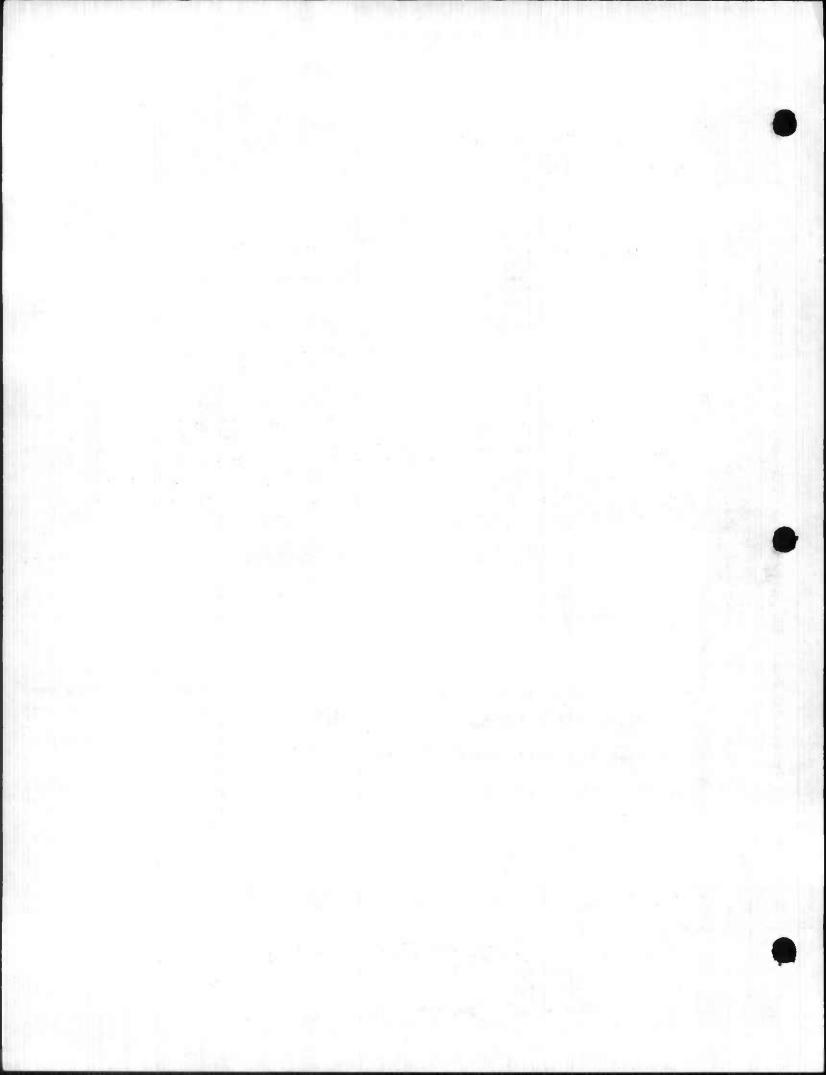
To the Funerel Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 T Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of pa 29d. Date signed (Month, Day, Year) 30. Name and address of person and th (Item 23a) (Type, Print)

Registrar

State

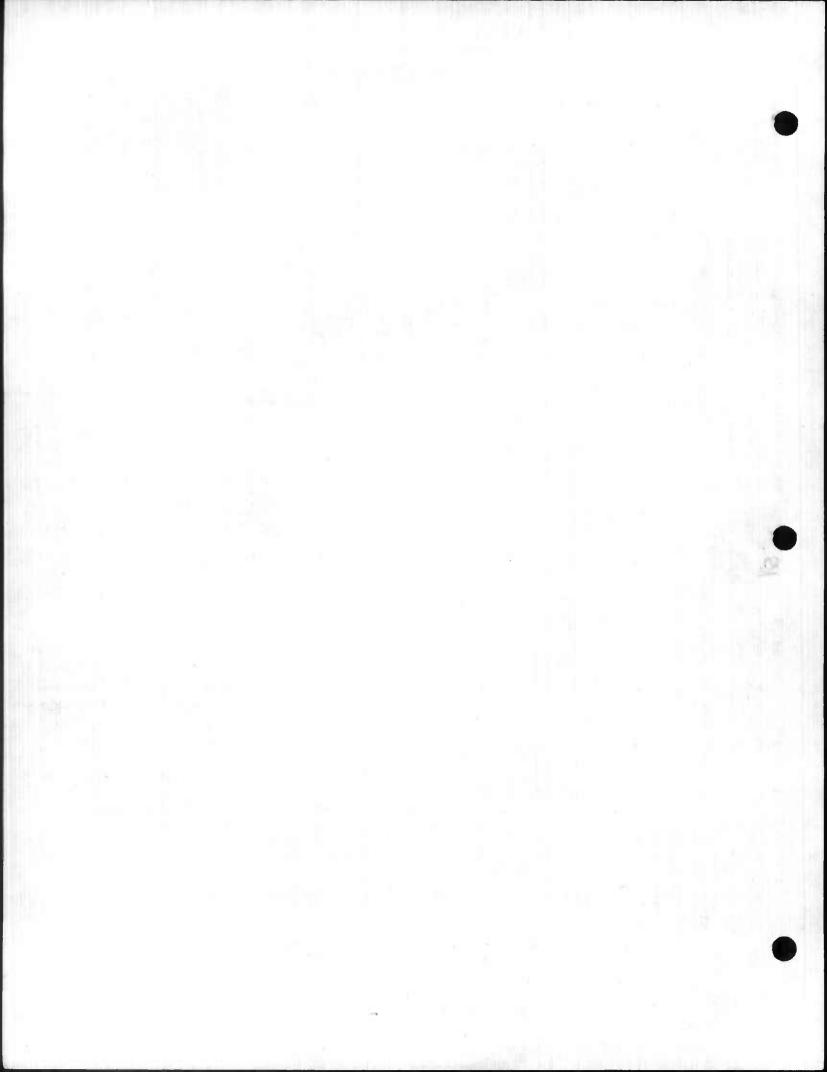
32. Registra/s Signature



State of Maryland / Department of Health and Mental Hygiene QQ

								Death			leg. No.			
hysician	1. Decedent's Name (									Date of Dea Month		1999	3. Time	
/Medical	James Sy1	vester	Snowder	n							-	, 1999	2:17	P.1
xaminer	4a Facility Name (# n	ot institution,	give street and n	number)			4	lb. City, Town	n, or Location	on of Death	4c. Co	unty of Deat	lh	
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neral ector	5. Social Security Num  217-30-645  Usual Residence of D	31	S. Sex 1 M 2 □ F	7. Age (In yr. 62		Yrs. If Ur Mont	hs Days	If Under 24 Hours	Min.	Dete of Birt (Month, De) an 1	(Year)	9. Birt Co 37 Mar	thplece (Stete buntry) yland	or For
	-	Ob. County		10c. C	ity. Town	or Location		-					10d. Inside	City Lir
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the norther	10e. Street and Numb		reet			10f.	Zip Code 217	701				of What Co		
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any injury or once.	21. Signature of Fune	ral Service Lic	censee			22. Name	and Addre	ss of Fecility					es, P.	
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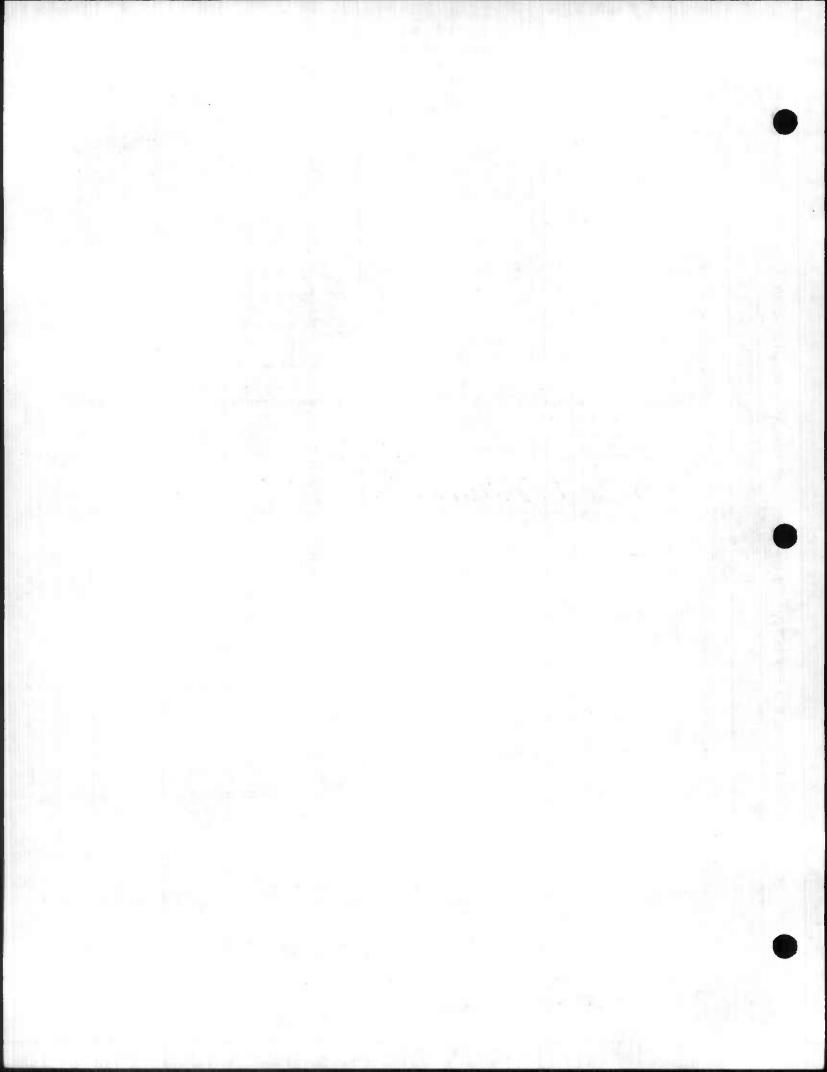
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q 1, 2 5 5 9

			Certificate of	f Death	Rec	. No.	42003
	1. Decedent's Neme (First, Middle, La	st)			2. Date of Death Month	Dev Yes	3. Tima of Death
Physician /Medical	George	W. Schaeffe	er, Jr.		December	25, 199	
Examiner	4e Facility Name (If not institution, giv	re street and number)		4b. City, Town, or Lo	ocation of Death	4c. County of D	eath
	Homewood Retire	ement Center		Frederic	k	Freder	ick
Funeral Director	5. Social Security Number 6. S	Sex 7. Age (In yrs.	Worths Day:		8. Date of Birth (Month, Day, Y Oct. 24,	(ear) 9.1	Birthplace (State or Foreign Country)
	Usual Residence of Decedent				OCC. 27,	1 /22  110	Lyland
how	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
Series Me	Maryland Frederic	k	Frederick				1 ☐ Yes 2X No
vith the Ma or 28s-f a be notified Director	10e. Street and Number		10f. Zip Code		100	. Citizen of Whet	Country?
oth v	6853 Buckthorn (			1703		U.S.A	
ther deeth v	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Hece - A Black, W	merican Indien, hite, etc.
or aft. or by F	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1□ Yes 2以N	o Specify:		Specify:	White
	15. Decedent's Ed	ducation	16a. Decedent's Usual Occ	upation	16	b. Kind of Busine	
	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of work red)	ing		
flied within Hygiene. ther then and, the Hear	10	College (1-40f 5+)	Farmer			Farming	
nd 2 should be file th and Mental Hy 77 is merked othe Traumetic avent,	17. Father's Neme (First, Middle, Last,	)		18. Mother's Name	e (First, Middle, Ma	iden Sumeme)	
should be filed vand Mental Hygie a marked other t turnetic avent, ID	George W. So	chaeffer, Sr.		Alice I	. Valen	tine	
2 sho	19a. Informent's Neme/Reletionship (		19b. Mailing Address (Street				
ealth n 27 ner tr	Betty Lou Chadwel		17650 Hardy	Road, Mour			
pomit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itan 27 is marked other than any injury or other traumatic avent, ma Health in the Itan I and I are the I are the I are I a	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Name of cometery, crematory or other p	lace)	Date 20	c. Location - City	or Town, State
Pages ment of bank of lury or of	4 Donation 5 Other (Specif		unt Olivet Cem	etery 1	2/28/99	Frederi	ck, Maryland
pemit. Departimonts any inje	21. Signature of Funeral Service Licer	1566	01in L. M	ress of Facility lolesworth	P.A. Fu	neral Ho	me
00549	Novert L	. Nelles	26401 Rid	ge Road, I	amascus,	Marylan	
	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not enter the mode of d	ying, such es cardiac	or respiratory erres	t,	Approximeta Intervat Between
Physician		1					Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a Aspi	iration pr	теитопі	a		2 Days
	Tooday in Journal	Due/to (d	or as a consequence of):	1 1			. /
bet risk			brovascular	Stroke			10days
sand selfra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	or as a consequence of):				
rificate be assecuted by physicien and as the buriel-transit	Cause (Disease or injury that initieted events	C					
	resulting in death) Last	0 0 00 00	r as a consequence of):				
		d					
of the death cerds to by the attendir letached for use	Pert It. Other significant conditions of	ontributing to death but not res	ulting in the underlying cause o	given in Part I.	23b. Did tob	ecco una contrib	uta to the cause of death?
at the did by the letached	D 1.	•			1 ☐ Yee	2 No 3	Probably 4 Unknown
	<u>Ретептіа</u>					^	
he lew requires that the death ce a has been signed by the attending 2 should be detached for use ompleted by Physician/	Mustaducal	cia			24a. Wes an performe		lb. Were autopsy tindings evailable prior to
has be pe 2 sh	- Myelody Spic	15.10					of death?
The lew requirements been stage 2 should	/ /				1 ☐ Yes	20 No	1 ☐ Yes 2 ☐ No
entification octor,	25. Was case referred to medical examiner?			26. Place of Deet	h (Check only one)	1	
hysic of his co	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 A Nursing Ho	me 5 Residen	ce 6 Other (5	Specify)
her ther there and a second	27. Manner of Death 1 Dending 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of injury 28c. Inj		28d. Describe how	injury occurred	
tal or Attanding P is after death. al Director: After led in by the funeri Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1[	Yes 2 No			
or Attanding Physician: I after death: Director: After this certifical I in by the funeral director, pertification: To Be C	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif)	ome, ferm, street, fectory, office y)	9	28f. Location (Stre City or Town,		r Rurel Route Number,
oral Dela	One Continue of Continue						
To the Hospital or Attanding Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page:  Medical Certification: To Be Com-	29a. Cartifier 1 Certifying Ph (Check only 2 Medical Exert one)	ysician: To the best of my knowner; On the basis of examina and manner stated.	wiedge, death occurred at the tion and/or investigation, in my	time, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and menne and plece, end	due to the cause(s)
othe othe omple	29b. Signature and title of certifier	Quita illumor somed.	29c. Lice	nse number	290	I. Dete signed (M	lonth, Day, Year)
F 3 F 8	X	MD MD		E 11 112		12/2	1/00
,	30. Name and address of person who		23a) (Type Print)	21643		14/2	144
	Dr. Hiren N.	5404 171	O Thomas	Tobasas	D. S.	ute in	Frederick
State	31 Date filed (Month Daw Year)	32. Registrer Signa		ווטבויווט ע	111110	100	MD 2170
Registrar	DEC 2	8 1999 Den	ve g.	lose 1			

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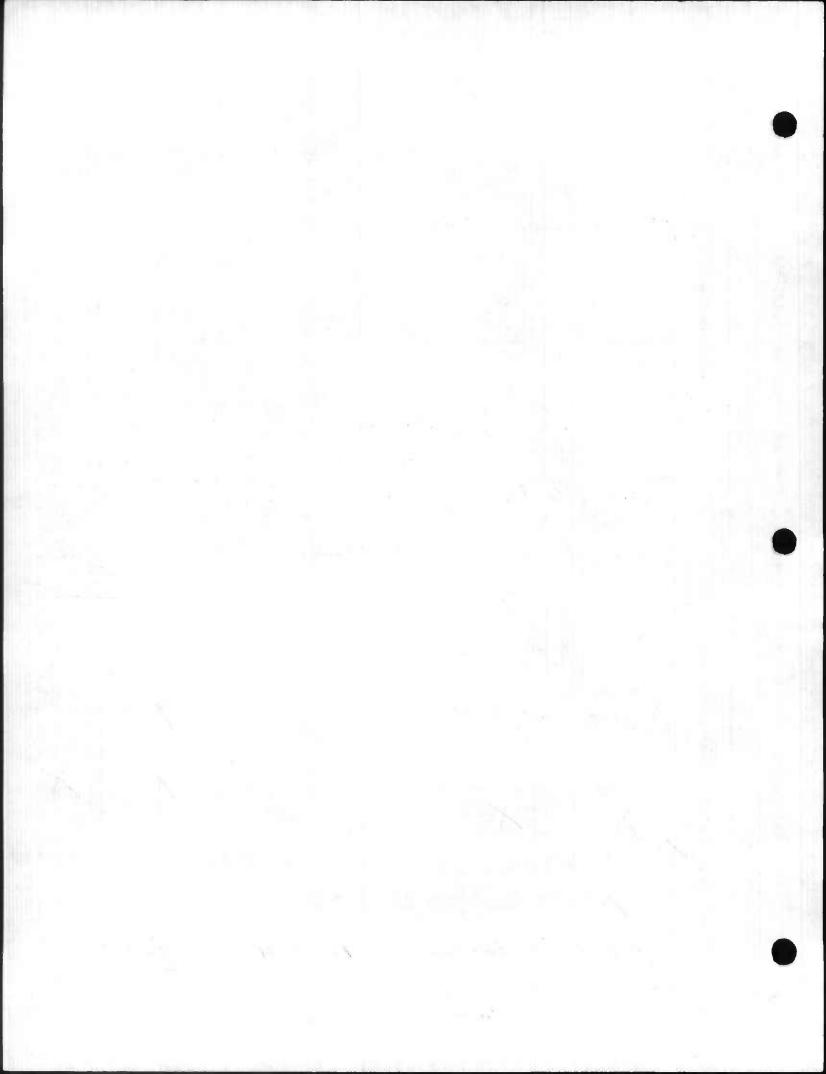


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Certificate of Death

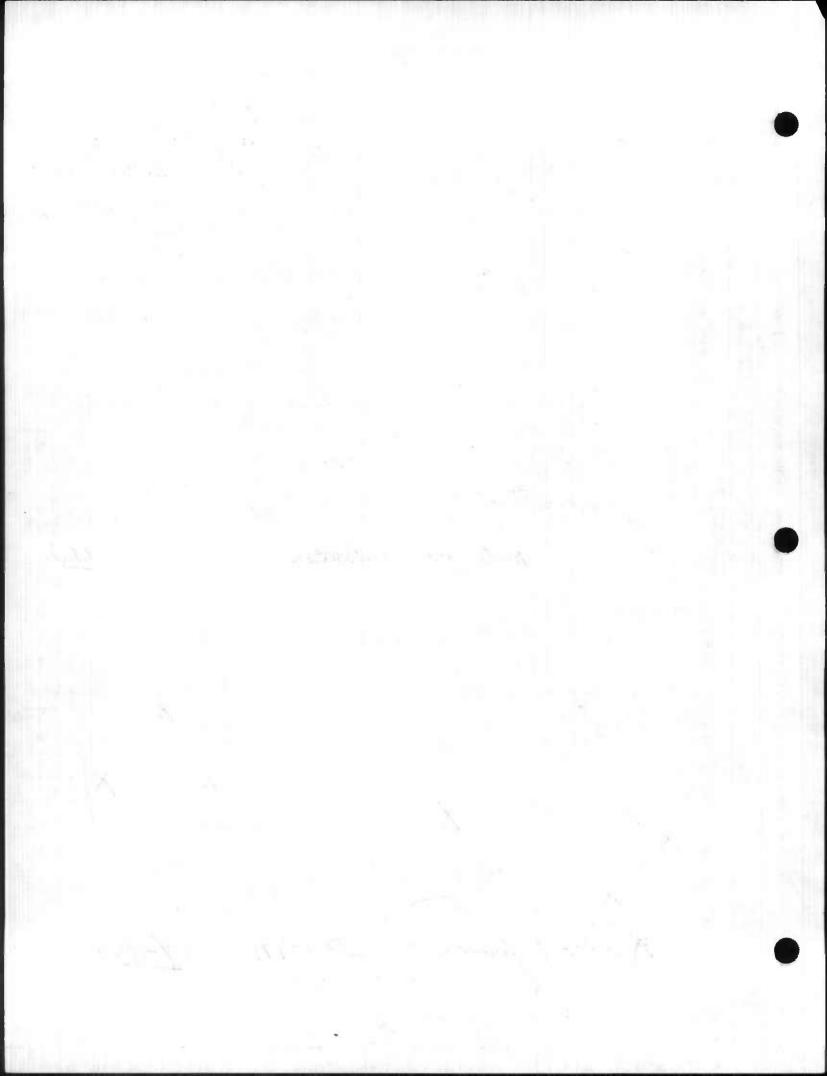
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	Certificate C	Dealli	Reg. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Gladys Smith	2. Date De Ce	of Death Imber 22, 1	3. Time of Death 7:20 pm
Examiner	4a Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of	Death 4c. County	of Death
	Frederick Memorial Hospital	Frederick	Frede	rick
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs. 8 Date	of Birth	Birthplace (State or Fore Country)
Director	220-26-0090 1 M 2 F 80 Yrs. Months Da		th, Day, Year) h 25, 1919	Maryland
to or 28a-f show the nourse at	Usual Residence of Decedent	riaic	11 23,1319	Haryranu
ě m	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lim
28a-f shownout at a court at a co	Manual and a Breatantal			1 ☐ Yes 2 ☐
Director	Maryland Frederick Thurmont  10e. Street and Number 10f. Zip Cod	•	10g. Citizen of W	final Country?
3 6	Tot. 2tp Coo		rog. Citizeri oi vi	vriat Country?
1 2	13240 Catoctin Furnace Road 217			d States
Funeral	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify Yes uban, Mexican, Puerto Rican, et	or No- 14. Race	e - American Indian, k, White, etc.
	1 Never Married 2 Married 1 Yes 2 No		Specify	
ě	3 ☑ Widowed 4 □ Divorced Year or Dates:	open,	Specily	white
Completed	15. Decedent's Education 16a. Decedent's Usual Oc	cupation ne during most of working	16b. Kind of Bu	siness/Industry
- 0	(Specify only highest grade completed) (Give kind of work do life. DO NOT use rel	ried)		
E	7 - Homemaker		self	
O	17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, A		e)
o Be	Howard Sweeney	Untel:		
Ĕ		Hattie	Wanter City of Your	Otata Zin Codel
		eet and Number or Rural Route I		
		in Furnace Rd,		
	20a. Method of Disposition 1 ÄBurial 2 ☐ Cremation 3 ☐ Removal from State	Date Date	20c. Location -	City or Town, State
	4 Donation 5 Other (Specify)  Blue Ridge Cemet	erv 12/27	/99 Thurmon	nt, Maryland
	21. Signature of Funeral Service-Licensee 22. Name and Ad			
	NO DRIV	Staurie		Homes, P.A.
		Main Street, Th	urmont, MD	21788
	23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or respira	lory arrest,	Approximate Interval Between
n		-		Onset and Death
1	Immediate Cause (Final disease or condition Consertine ) full for	colene		1 ax
н	resulting in death)  Due to (or as a consequence of):			
ě				[ [ n lma
Ē	Sequentially list conditions.  Due to (or as a consequence of):			109.0
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	Cause (Disease or injury			1
n/Medical	resulting in death) Last  Due to (or as a consequence of):			1
Š	d			
ᇤ				1
9	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23b	. Did tobacco use cor	ntributa to the cause of de
F.	gamares Left last		1 Yee 2 No	3 Probably 4 Unkr
ý	Jan 100 0 100 100		/\	
Completed by Physicial		24a	. Was an autopsy	24b. Were autopsy finding
ete			performed?	completion of cause of death?
Ē				1
			1□ Yes 20 No	1 ☐ Yes 2D No
8	25. Was case referred to medicat examine?	26. Place of Death (Check	only one)	Y .
10	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5	Residence 6 Other	er (Specify)
Ë	27. Manner of Death 28st Date of Injury 28b. Time of 28c. I	njury at 28d. Des	cribe how injury occurr	ed
Certification:		Yes 2 No		
100	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, offi building, etc. (Specify)	ce 28f. Loca		er or Rural Route Number,
en	4 Homicide building, etc. (Specify)	City	or Town, State)	
edical C	29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in m	e time, date and place, and due to by opinion, death occurred at the	o the cause(s) and ma time, date and place,	nner as stated. and due to the cause(s)
8	one) and manner stated.			
Σ	20b. Signature and title of sertifier 29c. Lic	ense number	29d. Date signer	(Month, Day, Year)
	K Mal L Kopun	-13971	12/2	4/99
	30. Name and address of person who completed cause of death (item 23a) (Type, Print)	7-111	/	411-
				-
	Robert Kaufman, 300 West Ninth Street, Fred	rick,		
-	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
State strar	DEC 2 7 1999			



State of Maryland / Department of Health and Mental Hygiene 99 42671

				Cei	rtificate of	Death		Reg. No.		
Dhysisian	1. Decedent's Name (First, Mic	idle, Last)					2. Date of Month	Death Day	Year	3. Time of Death
Physician /Medical	GANI	FRANK	SM	IITH			Decem			12:38 PM
Examiner	4a Facility Name (If not institut				4	4b. City, Town	n, or Location of De	eath 4c. County	of Death	
		k Memorial	_				erick		leric	
Funeral	5. Social Security Number	6. Sax 12 M 2 ☐ F	7. Age (In yrs. las		If Under 1 Year Months Deys	Hours 4	Min. (Month.	Dav. Year)	9. Birthpla Count	laca (State or Foreign try)
Director	220-32-5218 Usuel Residence of Decedent	, and	63	Yrs.			Oct.	16, 1936	Wahsi	ington,DC
p k	10a. State 10b. Cour	nty	10c. City,	Town or Lo	cation				10	0d. Inside City Limits
Many and sho	Maryland Fre	derick			Fred	erick				1 ☐ Yes 2 N No
or 28	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Count	lry?
23a 23a 23a 23a	6590 Whet	stone Dr.				217	703	Untied	Stat	es
1215-0020 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Hedgel Emories must be notified at empleted by Funeral Director	11. Marital Status 1 □ Never Married 20 M	erried 1 Yas	2 □ No	'	Wes Decedent of H I Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Originan, Mexican, I	n? (Specify Yas or Puerto Rican, etc.)	No- 14. Race Black Specify:	e - America k, White, e	etc.
DOOZ BOUTS B	3 Widowed 4 Divorc	ed Year or I	Detas: 54-57					Specify.	Whit	e
21215-0 ed within 72 ho bygiene. wr than 'naturi 1, the Healteal Completed	15. Deced (Specify only high	ent's Education hest greda completed)	A	(Giva	lent's Usuel Occup kind of work done	during most o	of working	16b. Kind of Bu	siness/Ind	ustry
21215-0020 within 72 hours at jiene. Then instural; or the instural; or the instural; or the institute of th	Elementary/Secondary (0-12		1-4or 5+)		OO NOT use retired			Country	C - 1	1 C
d 212 filed with Hygiene. Hygiene. Inf. free			5 +	riu	sic Teac		a Nama /First Mid	dle, Maiden Sumam		1 System
			C 4	4-1- C.						
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2 2 2 2	Jeanne P. Smi									
Baitimore, Normania Pages 1 and Department of Health Important: If Item 27 any Injury or other trans.	20a. Method of Disposition	ru / wire	20b. Plac	ce of Dispo	Sition (Name of	ne Dr.	/ Frede	rick, Mar		
Pages nent of h	1 ☐ Buriel 2 ☐ Crametio		State cen	netery, cren	netory or other plac					
Baltimore, bernit. Pages 1 al bepartment of Hea important: if Nem: any Injury or othe	4 ☐ Donation 5 Ø Other  21. Signeture of Funeral Service		bment Mou		ivet Ceme			99 Freder		
Baltii permit. P Department Importan eny injur	21. Signeture of Funeral Service	A CICATISON	1	)				r Funeral		
	naymo	nelles	erson					rederick,		21702
	23a. Parti. Enter tha disaase, shock, or neert feitura. L	or complications that ist only one cause on	caused tha death. eech line.	Do not ent	ar the mode of dyir	ng, such as ca	ardiac or respiretor	y arrest,		Approximete Interval Between Onset end Deeth
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Examiner	diseasa or condition resulting in death)	a. Hee	to m	40,	infare	tion			1	IN.
5			Due to (or	s a conseq	uence of):					
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s and altra	Sequentially list conditions, if any, leading to immadiete		Due to (or a	s a conseq	uence of):				i	
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x 6876/ entificate be sing physicle as as the bu	resulting In death) Lest		Due to (or e	s e conseq	uence of}:				1	
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that the death that the death detached for detached for y Physicia	reit ii. Other significant condi	done contributing to d	oath out not result	rig in the di	idellying cause giv	en in rait i.		Yes 2 No	3∏ Prob	
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ords requires seen sign hould be								es en autopsy	24b. We	ere autopsy tindings allable prior to
							_   P	erformed?	COT	mpletion of cause death?
The law The law page 2 s								ÚYes 2□No	1	Ves 2□ No
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Of Vita Physician: this certific ral director, TO Be (		Hospitel:	Inpatient 2 EF	VOutpatien	1 3 DOA Oth	er:			or (Consile	d
0 5 5 5		28a. Date	of Injury 2	8b. Time of			-	esidence 6 Other		9
sion leath. tor: After the fune cation	1 Natural 5 Pend	ding (Mor	nth, Day Year)	Injury		k? Yes 2∐No	0			
Division of the division of a ster death.  In Director: After the din by the funera Certification:	3 Suicide 6 Coul	d not be	e of Injury - At hom	e, farm, str	eet, fectory, office		28f. Locatio	n (Street and Numb	er or Rural	l Route Number,
affer din b	4 Homicide	build	ing, etc. (Specity)				City or	Town, Stete)		
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification	29a. Certifier (Check only 2 Medical	ring Physician: To the	asis of examination	dge, deeth	occurred et the tin	ne, date end pinion, death	place, and due to to occurred at the time	he cause(s) and ma ne, date and place, a	nner as sto	ated. the cause(s)
thin 2	one) 29b. Signature and file of certif		nner stated.	-	29c. Licens	e number		29d. Data signed	1 (Month I	Day Year)
T 1 2 5 8	N The Control of Allerin	PRI	0	/	TO LICONS	120	7	12/2	1/00	3
	I my	0-10/2	ner		1	134	11	1421	199	f
5.00	30. Name and address of person	on who completed cau	se of death filem 2	3a) (Type,	Print)	NIMA	,	1		
	200 W 9	rs Sr. F	rever	ch	1110	+110	/			
State	31. Dete filed (Month, DEC	<b>2 2 19</b> 99	Registreris Signetui	re	1.	j.				
Registrar		1933	1 miles		D. de	Day V	7			
DHMH 16 Rev 6/95					14	- 4				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 42672 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **JAMES SEYBOLT** DONALD December 19, 1999 1:36 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 2□ F Days 87 Nov. 6, 1912 577-03-6592 Washington, D.C Usual Residence of Decede 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Clarksburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13809 Lewisdale Road 20871 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Sealtest Dairy Driver 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surname) James M. Seybolt Iva Nelson Seybolt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) daughter-in-law 6908 S. Osborne Road, Upper Marlboro, MD 20772 Margaret L. Seybolt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ResthavenMemorialGardens | 12/22/99 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximata Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Acritic Stenosi

**Physician** /Medical Examiner

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Box 68760.

P.O.

Records,

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Division

Physician

/Medical

Examiner

**Funeral** 

Director

x 28e-f show

than "natural", or items 23s or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours effact. Department of Hasith and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itam any Injury or other traumatic event, the Hasing Inspute

Baltimore, Maryland 21215-0020

Directo

Funeral

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Physician/Medical Examiner à Completed 80 Cartification: To

edical

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Esophagen dance

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed?

1 ☐ Yes 20HNo 1 Yas

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Delatural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of bedth (Item 23a) (Type, Print)

1999

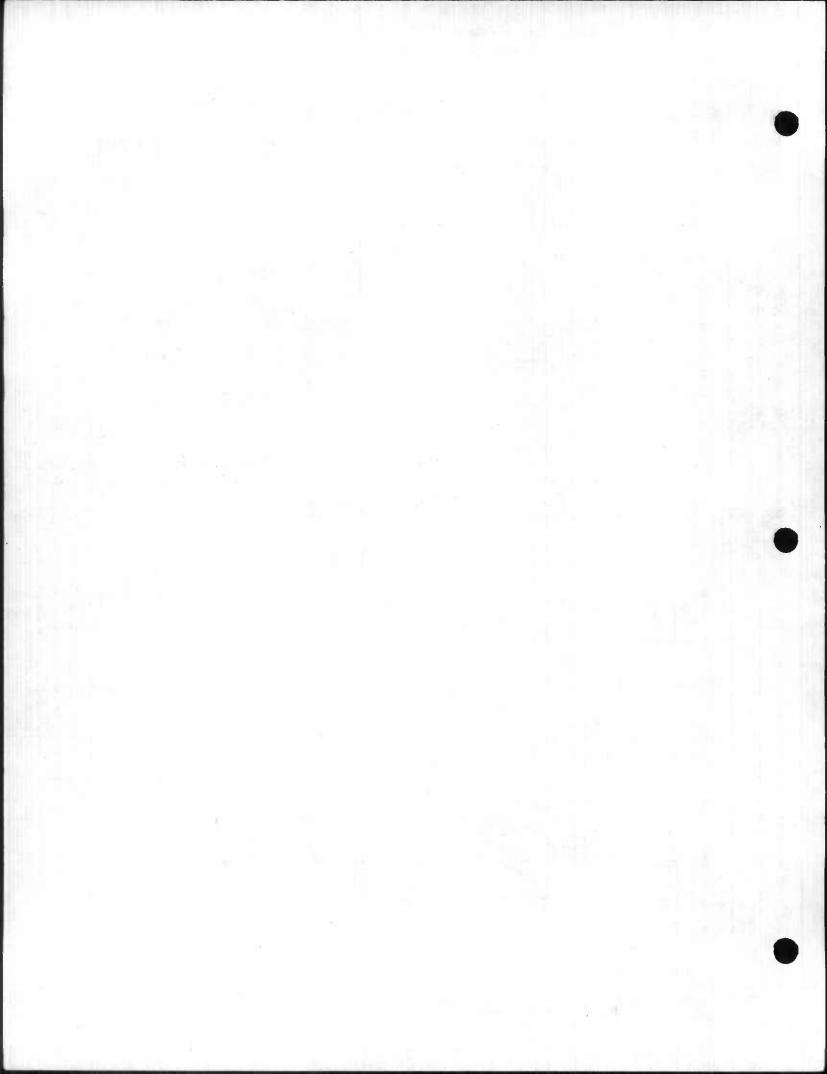
Pearre 300 West Ninth Street, Frederick, Maryland 31. Date filed (Month, Day, Year) DEC 2 1

State Registrar

P8 27 00

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cariffor completaly filled in by the tuneral director, I



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth December 21, 1999 1:30 AM Edward James Templeton 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Abingdon Harford 3512- 2C Thomas Pointe Ct. If Under 24 Hrs. Hours Min. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) M 2DF Months Deys Yrs. June 28, 1928 New York 116-20-3564 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3512 - 2C Thomas Pointe Ct. 21009 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 120 Yes 2 □ No If Yes, Give Year or Dates: 1945-64 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (u/k) Gordon Cecil Romain Templeton Daisy 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3512 - 2C Thomas Pointe Ct., Abingdon, Maryland 21009 Dorothy R. Templeton, Wife 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation Wother (Specify Entombment Highview Memorial Gardens 12-23-99 Fallston, Maryland Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediete Cause (Finel disease or condition resulting in death) RENAL CELL CARCINOMA Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2K No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work?

**Physician** /Medicai Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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7 is marked other then "natural", or items traumatic avent, the Madical Examiner in

other

ò permit. Page Department of Important: If eny injury or page.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

altimore.

Director

Funeral

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Examiner Physician/Medical P Completed Be Certification: To

ician and burial-trans physician s the burial 88 esn signed by page 2 s has certificate funeral director, this After

certificate be executed Division of Vital Records, Hospital or Attanding Physician: after death. 24 hours a To the within 2

1041

Registrar

Medical

Natural

3 Sulcide

29a. Certifian

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of cortifier

31. Date filed (Month, Day, Year) 32. Hapistrar's Signature

DEC 21

5 Pending

investigation

6 Could not be determined

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SHMFM

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

10753

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and dua to the ceusa(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and dua to the cousa(s) and manner as exerced.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. License number 038409

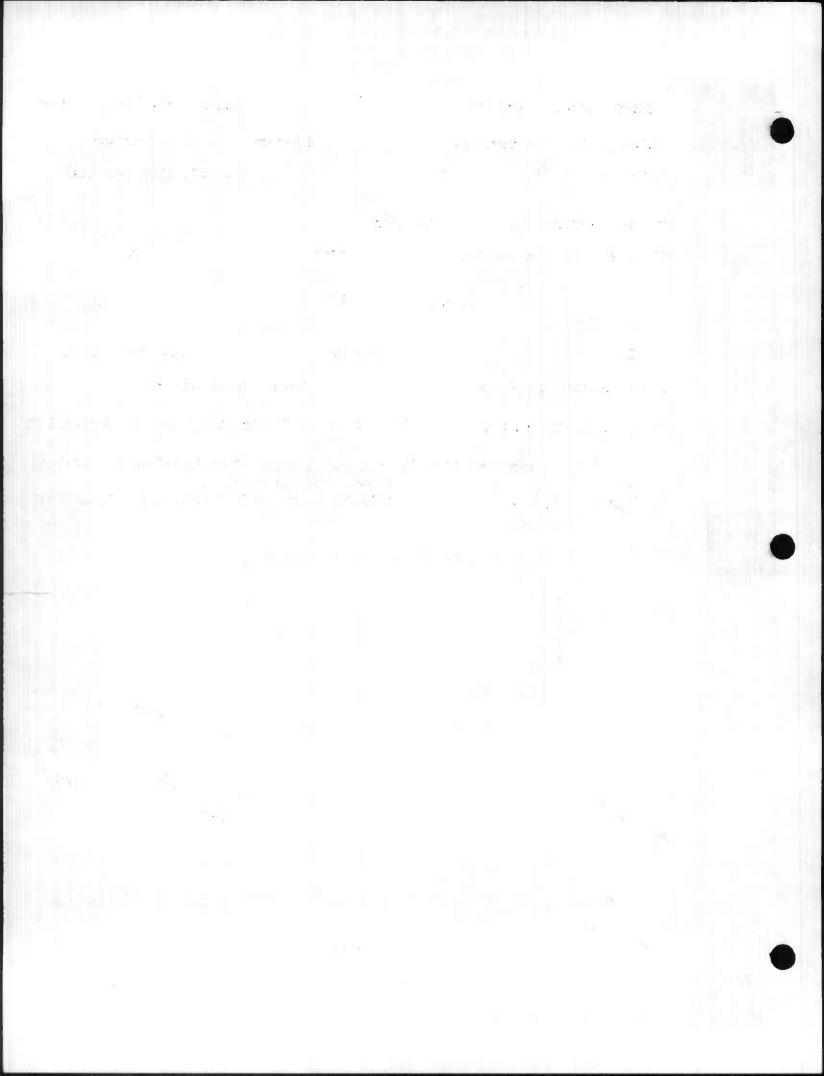
1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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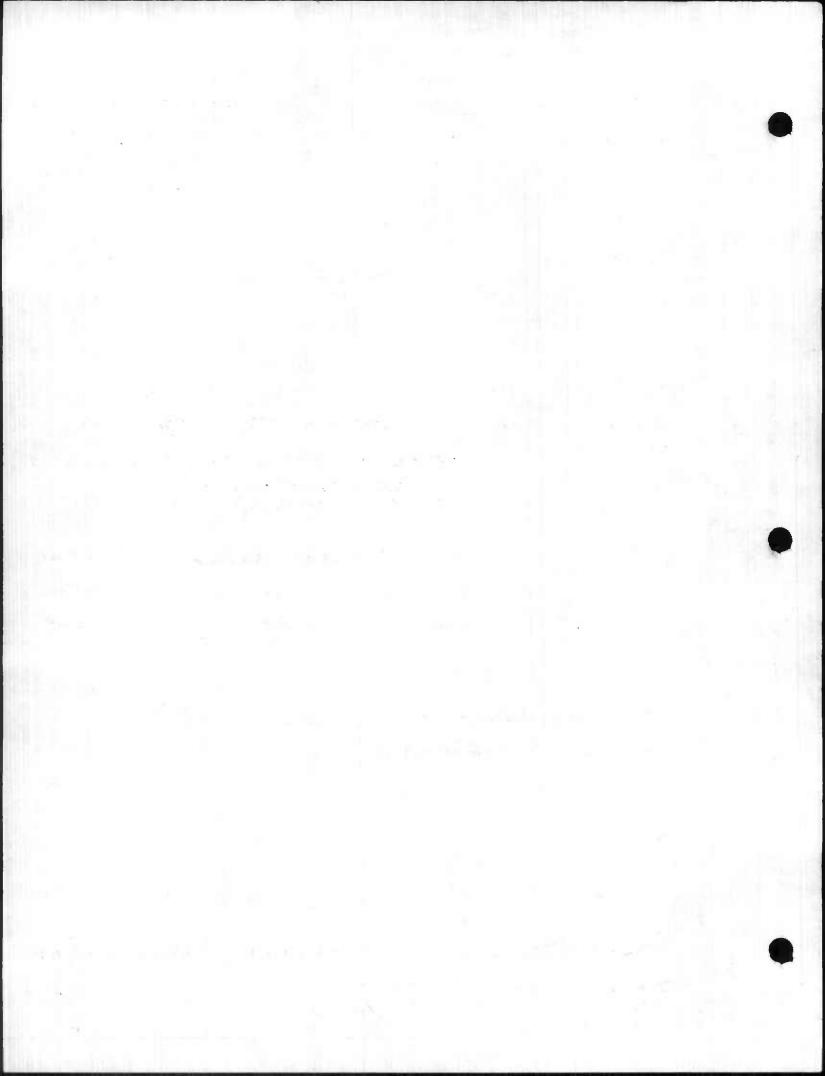
29d. Dete signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 99 42674 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death December 22 **Physician** Madeline Thompson 11:55 P.M /Medical 4a Fscility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Forest Hill Forest Hill Harford H Under 24 Hrs. B. Date of Birth (Month, Day, Year)
June 30, 1911 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
W. Virginia **Funeral** Months Days 1 M 2 XF 214-22-8921 88 Director Usuai Rasidence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 200No Directo Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2214 Watervale Road 21047 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Àq 3 ₩ Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental i Important: If Item 27 te mented or William Leslie Allen Sarah (u/k)19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Mele - Daughter 911 Monte Avenue, Fallston, Maryland 21047 altimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 120 Buriel 2 Cremetion 3 Remove from State 8 4 ☐ Donation 5 ☐ Othar (Specify) Fallston U.M. Church Cem. 12/28/99 Fallston, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licen McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21014 Approximata interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last poor or P.O. Box 68760 Physician/Medical Due to (or as e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contributs to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown descarp wolf 2 gurgeres signed b Records, p 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen 20 No 1 Yes 2 No Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Alursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Panding investigation 1 Delatural 2 Accident death. 1 Yes 2 No or Attendi after death. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 24 hours a Funeral D 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely if 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03227 December 27, 1995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CISW, MACPho DOVIDS. 31. Date filed (Month, Day, Year) 32. Registrer's Signature DEC 2 9 1999 Registrar

**DHMH 16 Ray 6/95** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42675

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miner		cility Name (If not institu		street and num	ber)			4	lb. City, Town		ion of Death	4c. County		
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Physician/N				l									1	
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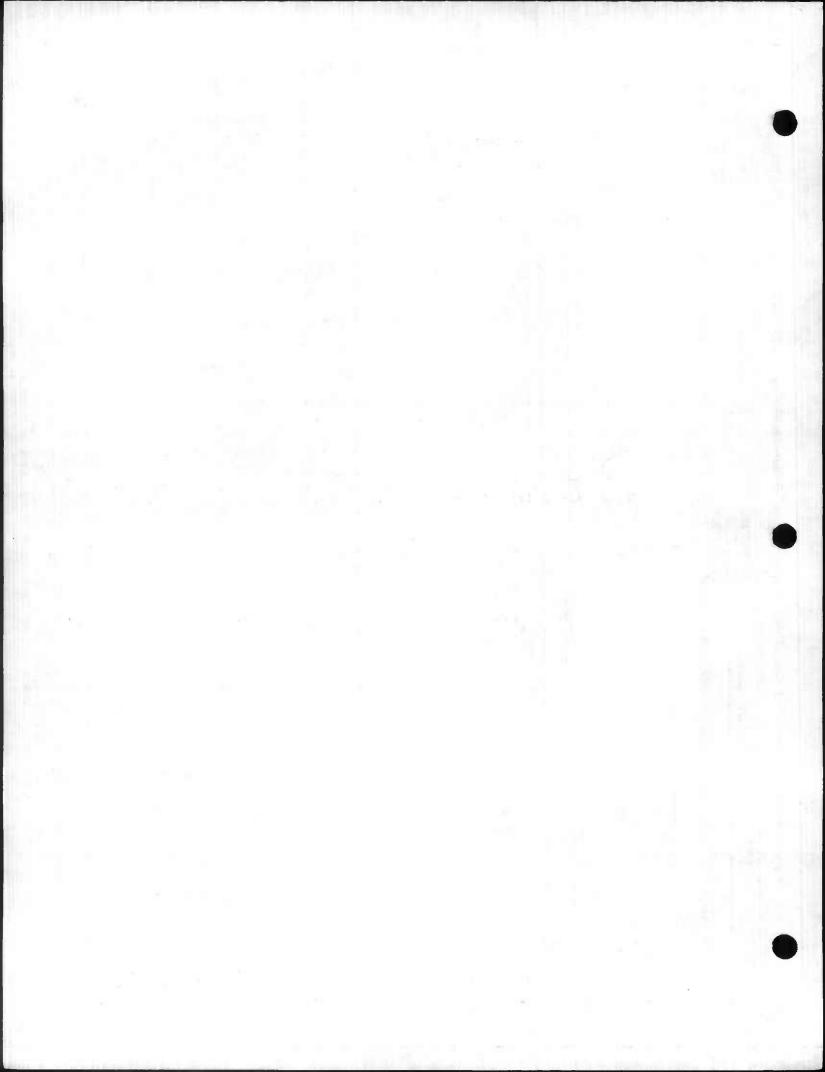
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State of Maryland / Department of Health and Mental Hygiene 99 42676

	1. Decedent's Neme (First, Middle, La	st)			2. Date of Death	Day	3. Time of Death
Physician /Medical	John	Crockett Tibb	S		December	30, 19	99 3:40 AM
Examiner	4a Facility Neme (If not institution, giv			4b. City, Town, or	Location of Death	4c. County of	Death
	SHADY GROVE			ROCKV:			OMERY
Funeral Director	210-24-0923	7. Age (In yrs. In:	st birthday) If Under 1 Yea Months Days			7926 V	B. Birthplace (State or Foreign Country) Inginia
D R at	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Hedah Hedah tor	Maryland Montgom	erv Dam	ascus				1 ☐ Yes 2 ☑ No
or 28s-fs be notified Director	10e. Street and Number	20	10f. Zip Code		10	g. Citizen of Wh	at Country?
23a canting	24707 Ridge Roa	ad	2	20872		U.S.A.	
r heme 23a diner must Funeral	11. Maritel Stetus	12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		American Indian, White, etc.
by F	1 Never Merried 2 Merried 3 Widowed 4 XDivorced	1 ☐ Yes 24 No If Yes, Giva Year or Detes:	1□ Yes 2Ã No	Specify:		Specify:	White
	15. Decedent's Ed	ACREA STREET	16a. Decedent's Usual Occa	upation	10	6b. Kind of Busi	
ygiene. ver than "natur rt, the Medical. Completed	(Specify only highest gra Elemantery/Secondery (0-12)	de completed)  College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done tife. DO NOT use retir	e during most of wo	rking		
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Be sed	17. Father's Neme (First, Middle, Last)				me (First, Middle, Mi		
To To	James Tibbs			Flora		Etwell	
Taun Traum	19e. Informent's Neme/Relationship (		19b. Mailing Address (Street 24707 Ridge			1111	ate, Zip Code) 20872
other 2	20a. Method of Disposition		ce of Disposition (Name of netery, crematory or other pl				ity or Town, State
700	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Light Carried Carried	netery, crematory or other pl Paul's Ceme	tery			sville,Marylan
injur	21 Signature of Funeral Service Licen	/	22. Name and Add				,
9 1 2 8	1 Hovert L.	Williams	01in L. M	lolesworth	P.A., Fu	neral H	lome
	23a. Part1. Ever the disease, or company shock, or party failure. List only	olications that caused the death.	Do not enter the mode of dy	ring, such as cardia	Damascus,	Maryla	Approximate
sician	snock, or team railure. List only	one cause on each line.					Intervel Between Onset end Death
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niner	resulting in deeth)	a. Myocardic  Due to (or e					
nine		b. Respiratory Due to for a	Failure				8 days
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edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	V	s a consequence of:	anary 111de	rile		years
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sici	Pert II. Other algnificant conditions of	ontributing to death but not resulti	ing in the underlying cause g	iven in Part I.	23b. Did tob	acco use contr	fourte to the cause of death?
Phy					1 Yes	2 □ No 3	Probably 4 Unknown
d be d					040 1010-	audas	24b. Were autopsy findings
page 2 should					24a. Wes an performe		available prior to completion of cause
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director, page 2 s	25. Wes case rafarred to medical			no piece of p	1 Yes	/ \	1 ☐ Yes 2 No
director director	examiner?	Hospitel: 10 Innation 2 TE	R/Outpatient 3 DOA	thor	eth <i>(Check only one)</i> Home 5□ Residen		(Spacify)
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ed in by the funer Certification:	1 Neturel 5 Pending investigation			Yes 2 No			
d in by the funera	3 ☐ Sulcida 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fectory, office		28f. Location (Stre City or Town,		or Rurat Route Number,
o di							
To the Funeral Director: Mer this certificompletely filled in by the funeral director,  Medical Certification: To Be (	(Check only 2 Medical Exam	veician: To the best of my knowle liner: On the basis of examination	edge, death occurred at the in end/or investigation, in my	time, date and place opinion, death occu	, and due to the cau urred at the time, dat	use(s) and manne e and place, an	ner as stated. d due to the cause(s)
Med	29b. Signeture end-little of certifier	end menner steted.	29c Licer	nse number	296	d. Data signed (	(Month, Day, Year)
. 8		Jule imp		17791			30,1999
	30. Name and address of person who	completed cause of death (Item 2	(3a) (Tuna Print) Dane	J 11-11			/
	30. Name and address of person who of Veirs	Mill Rul.	Rockull	a Holden,	M.D. 20851		
State	SO 9 Veirs 31. Date filed (Month, DayAN 0 3	32. Registra s Signatur	la ,				
Registrar	JAN 03	2000 Janes	Ø. A	bay.			
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DHMH 16 Rev 6/95

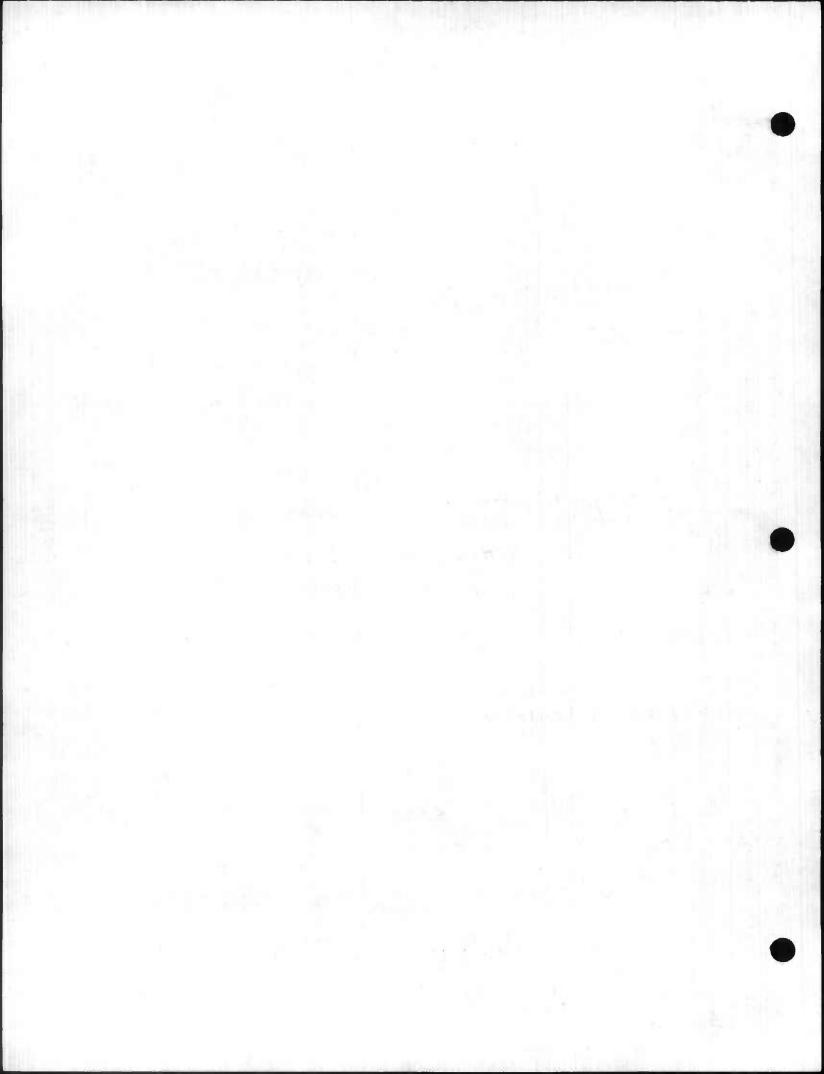


State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 27, 1999 4c. County of Death HOWARD TULL DECEMBER 3:30 AM /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 21, 1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 210-12-8265 80 Yrs. Director Usual Residence of Decedent 10a. Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at the Marvia Maryland Frederick Thurmont 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a or must be 21788 11408 Hessong Bridge Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 X Yas 2 No If Yes, Give Yeer or Detes: filed within 72 hours after 1 Nevar Married 2 Married 1943-1946 White Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondery (0-12) College (1-4or 5+) Security Federal Government 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Mental Important: If hem 27 is marked of any injury or other traumatic events. 2008. Sarah E. Peregoy Tul1 Joseph 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 11408 Hessong Bridge Road, Thurmont, MD 21788 Janice L. Tull/Spouse 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donelion 5 ☐ Other (Specify) Mt Saint Mary's Cemetery Dec 30, 1999 Emmitsburg, MD stup of Funeral Service License 22. Name end Address of Facility Keeney & Basford P.A. Funeral Home KIDOWON 21701 M00706 106 East Church Street, Frederick, MD Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Examiner RESPIRATERY ician and bunal-transit the death certificate be executed Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician the burial Box 68760 Physician/Medical Due to (or es a consequence of) USB Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown HTRIAL FIBRILLATION þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? a No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Day Year) 27. Mennar of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No invasiigation a Funeral Director: A Figure 1 Street Silvers of Figure 2 Street Silvers Silve 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifie To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Vitarello, MD, 180 Thomas Johnson Drive, #202, Frederick, Maryland 21702 John A.

**DHMH 16 Rev 6/95** 

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 1999 December 29 Martin Edward WEMPE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington County Hospital Hagerstown Washington If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Min. Months Days 10 M 20 F Hours 220-10-3284 79 JAN. 7 1920 Maryland Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Frederick Street 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1□Yes 2☑No Specify Specify: p 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Controller Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) e Edward Martin Wempe May Agnes Firey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Wolf - Nephew 13306 Unger Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 1/3/2000 | Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 mille 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown ula 24b. Were autopsy findings aveilable prior to completion of cause of death? Was an autopsy performed? 25. Was case referred to medical axaminer? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

physician and is the burial-trans 98 980 has page

After this

or Attending

Box 68760,

P.O.

Records,

Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

tem 27 la marked other than "natural", or itema 23a or 28a-f ahow other treumatic event, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within Depertment of Health and Mentel Hygiens. Important: if item 27 is marked other than "r eny injury or other treumatic event, me Mentel

**Physician** 

/Medical Examiner

the Maryland

Baitimore, Maryland 21215-0020

Examine Physician/Medical þ Completed Be Certification: To To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

edical

1 Yes 2 No

27, Manner of Death 1 Hatural

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospital:

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

3 DOA

1 Yes 2 No

Other:

29c, License number

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

4 Nursing Home 5 Residence 6 Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. ner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) and manner steted.

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29b. Signature and title of certifier

(Check only one)

29e. Certifier

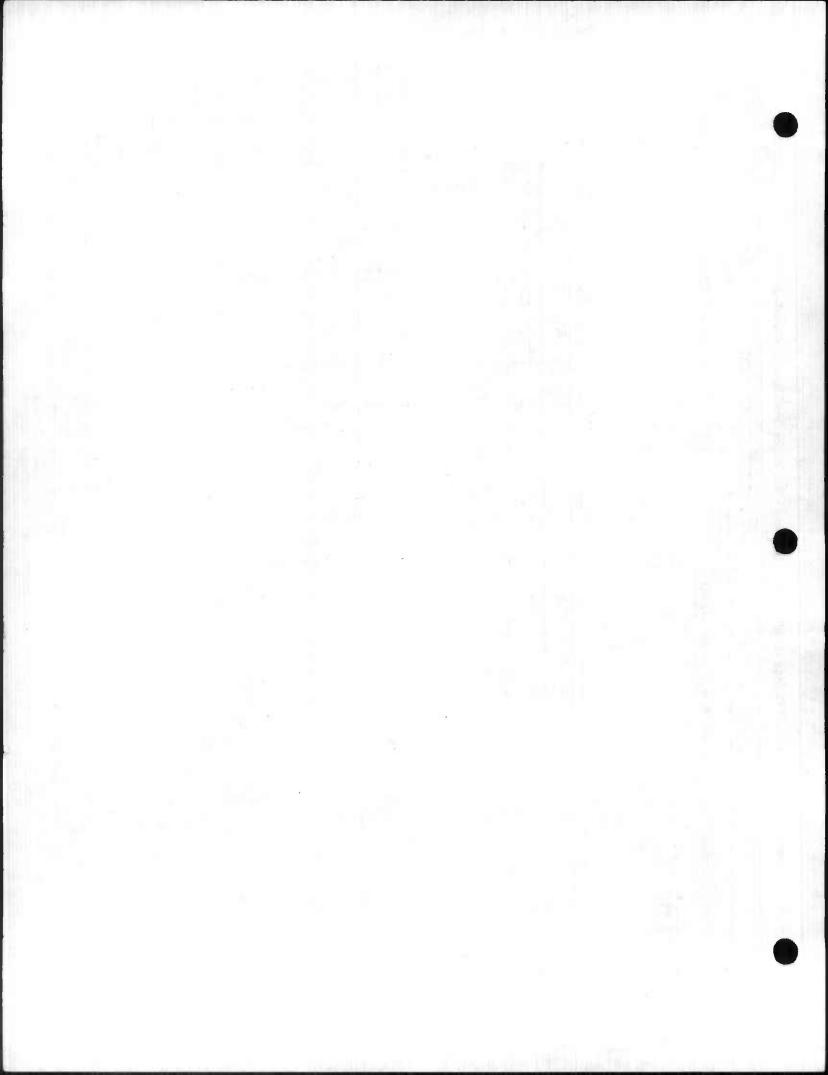
30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar

100 31. Date filed (Month, Day, Year) DEC 3 0

190 32. Registrar's Signature Lyce



Registra

State

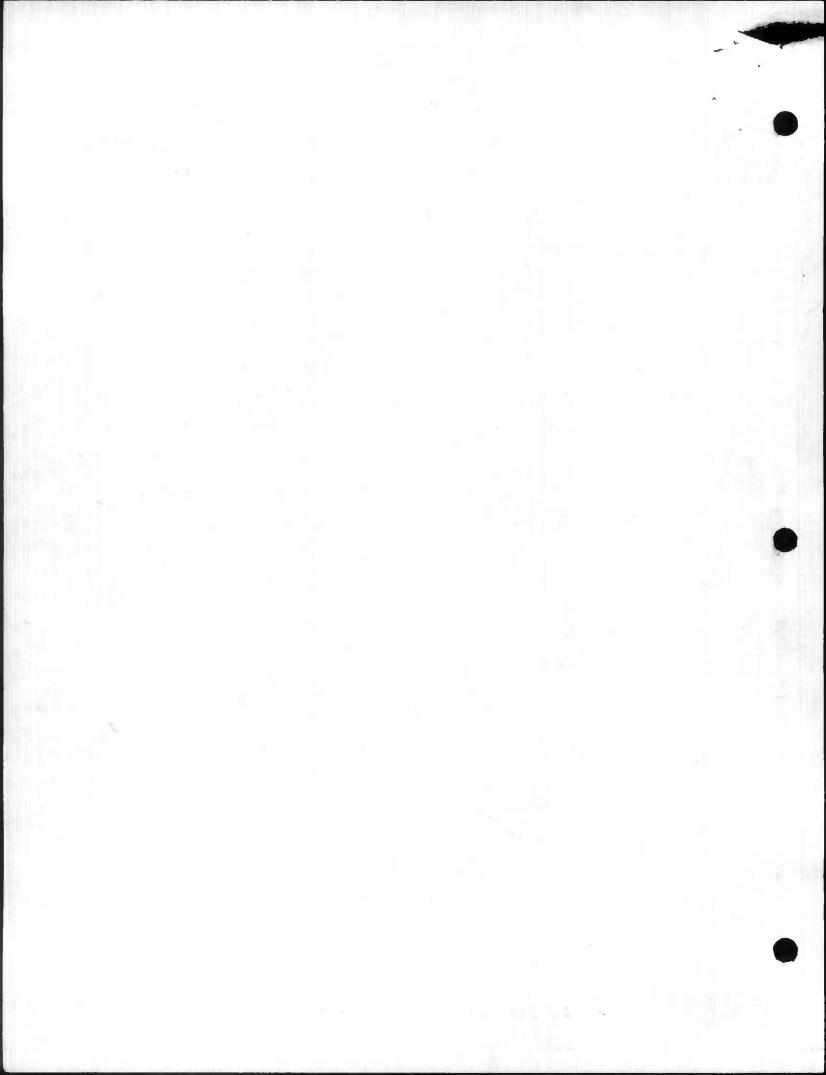
TARIQ MAHMOOD

31. Dete filed (Month, Day

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** E WARFIELD 12 22 10,53 PM /Medical Havre de Grace ITMX

Hunder 1 Year I Hunder 24 Hrs. 8. Dete of Birth
Months Days Hours Min. 8. Month. Day, Year)

Sept 10, 1909 4a Facility Name (If not institution, giva street end number) 4c. County of Death REORD MEM HOSP, +Al

REORD MEM (In yrs. last birthday) Examiner HAKFORD 9. Birthplace (State or Foreign Country) 5. Social Security Number Sex 1□ M 22 F **Funeral** 218-09-9063 Yrs. Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow ahow Aberdeen 1 Yes 2H No Funeral Director 10e Street and Number 10f. Zip Corle 10g. Citizen of What Country? 6 1500 Mitc 21001 USA LANE 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: BIACK 'natural', or 1 ☐ Yes 207No Specify by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Civil Service Elementary/Secondary (0-12) College (1-4or 5+) Aberleen House Keeper-Supervisor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be finent of Health and Mental I limit: If Item 27 is marked of Hollingeworth Lloyd Hollingsworth

19e. Informent's Name/Relationship (Type, Print) Parker Emil 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Mitchell Emily Johnson - daughter Abordeen Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, Stefa 1 Burial 2 Cremation 3 Removal from State Union United Meth. 12-28-9 4 ☐ Donaflon 5 ☐ Other (Specify) berdeen, 22. Nama end Addrass of Facility BEARD Funeral Hemo 21. Signetura of Funaral Sarvice Licensea Disa Scatt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final one week disease or condition resulting in death) Examiner Examiner ore week Dehydration and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Hypertensian 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Anemia this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturel 5 Pending investigation To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: At completely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 1RZA A-BAKAD D43115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/5 5. Union Ave., HVD,

Registrar

1999 Registrate Signeture

Secret the freedy

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42681

				olate of Mary	-	ertificate of			Reg. No.	
	Physic		Decedent's Name (First, Middle, Lest     T 3 LID	,	m			2. Dete of Dea Month	ath Day	3. Time of Death
d	/Medi Examir		4a. Facility Name (If not institution, give	A M. WYAT' street end number)	T		4b. City, Town, or	Dec.	29, 19	
4	LXaiiiii	ici		The second secon	- Ma . Car		ising S		Ceci	
	Funerai Director		131-01-3234	7. Age (In	yrs. lest birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	h y, Year)	9. Birthplece (State or Foreign Country)  Jorth Carolin
	and **		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation				10d. inside City Limits
	Marylan fahow	tor	MD Harford		Street					1 □ Yes <b>XX</b> io
	r 28a	Director	10a. Street and Number			10f. Zip Code	<del></del>		10g. Citizen of Wh	hat Country?
	th with	ai D	840 Highland	d Road		2115	4		USA	
020	72 hours after death with the Maryland natural; or items 23a or 28s-f ahow deal Examinet must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marriad  3 ☐ Never Married 4 ☐ Divorced	12. Was Dacedant Evar Armed Forces? 1 ☐ Yas 2 ☐ Yo If Yes, Give Year or Datas:		Was Dacedant of H If Yes, specify Cube 1 ☐ Yas 3 ☐ No		Specify Yas or No- to Ricen, atc.)	14. Race Black,	- Americen Indian, , Whita, etc. Mite
21215-0020	9	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondery (0-12)	cetion le completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wa	orking	16b. Kind of Bus	Iness/Industry
	tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)		nome	naker	18. Mother's Ne	me (First, Middle,	Meiden Sumeme	)
Maryland	0 5 0	To B	011ie Sheet	cs			Elizab	eth Mi	ller	
lan	d 2 should th and Mer 7 is merka treumetic		19a. Informant's Name/Relationship (Ty			ing Address (Street	end Number or R	ural Route Numbe	r, City or Town, S	itete, Zip Code)
dî.	en leal		Elvara W. Petty-			Highlan				154
Baltimore,	Pagas nant of H ant: If ite		20a. Method of Disposition  1 XXX rial 2 Cramation 3 F  4 Donation 5 Other (Specify)			osition (Neme of ametory or other please View Ce)		1/2/200		st Hill, MD
Balt	permit. Pagas 1 Department of H Important: If its any Injury or ot once.		21. Signature of Funeral Service Licens	- Twel	1-1 2	2. Nama and Addre	ss of Facility	600 N		., Delta,PA
	Physician /Medical Examiner	If	Immediate Cause (Final disease or condition resulting in death)	a	death. Do not en	i moniH	ng, such as cerdia	c or respiratory ar	rast,	Approximata Interval Between Onset end Death
	be axecuted sician and bunal-transit	Examiner	Sequentially list conditions,	Due	to (or es e conse	quence of):				
Box 68760,	tificate og phys as tha	edicai	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Due	to (or as a consec	quence of):				
	daath cert a attandin d for use	icia	Part II. Other significant conditions con	atributing to death but no	t reculting in the I	indedylna ceuse aiv	on in Part I	23h Did t	ohecco use cont	ribute to the cause of death?
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Vital Records,	aw requir	Completed b	-ASCVD	- P	P				an autopsy med?	24b. Were eutopsy findings evailable prior to complation of cause of death?
- B	Tha is	EOC	-MH					1 🗆 Y	es alkino	1 ☐ Yes 2 No
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of	hysic this ce	2	1 □ Yas 2 No		2 ER/Outpatie		4) Nursing I	Home 5 Resid		
Division (	dlng F h. After funar	ation:	27. Mitnner of Death  1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Yee	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	d
Divis	s ofter deat of Director: ed in by the	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, farm, st pecify)	treet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Diract completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exar and menner stated.	knowledge, deat minetion and/or in	th occurred at the tin	ne, dete end plece pinion, death occu	e, end due to the durred et the time, d	cause(s) and ment dete end plece, en	ner es stated. Indidue to the cause(s)
	To the To the comple	N	29b. Signature end title of certifier	ille ms		29c. Licens	2800,	1	29d. Date signed	(Month, Day, Year)
	P		30. Name and address of person who co	mpleted cause of death	(Item 23p) (Type.	Print) AVE	HA 6	Met.	7078	,
П	Sta	te	31. Date filed (Month, Day, Year)	32 Registrer's S	Signature	4 Son	1	1		

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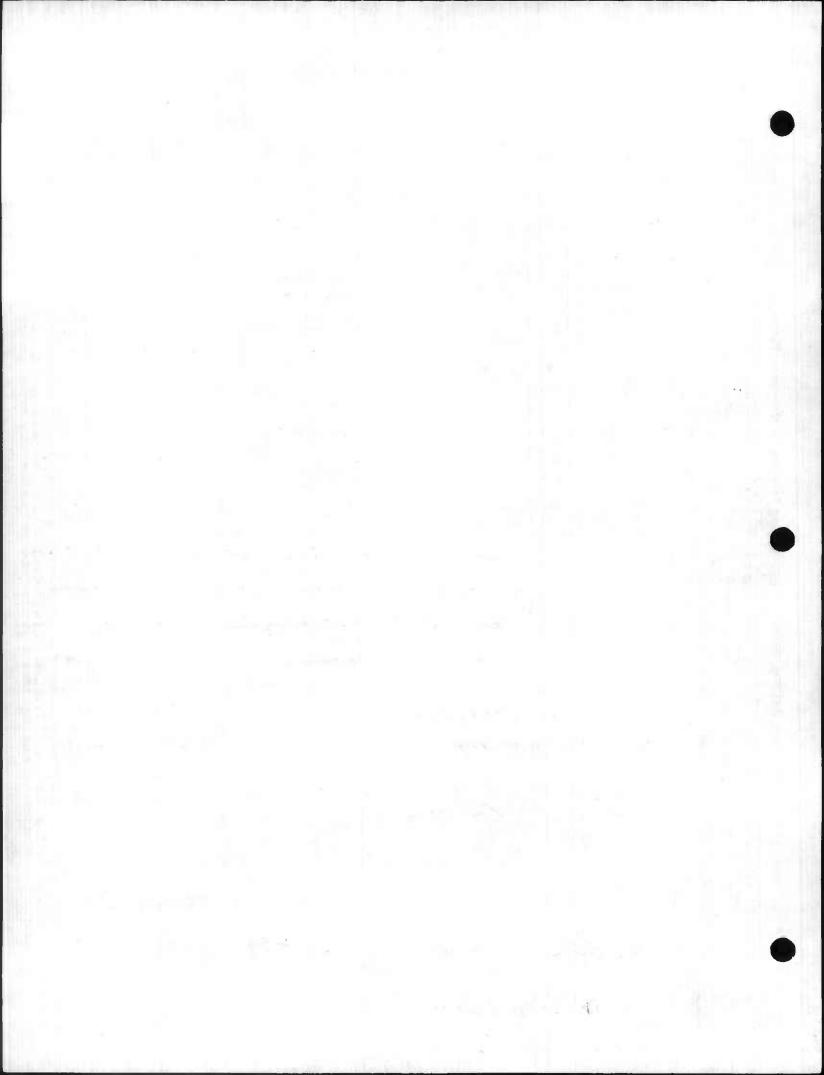
State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death 19, 1999 **Physician** He1en December Winpigler Catherine 9:00 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Hours Days 1□M 2⊠F Months Director 213-24-8095 March 21, 1920 Maryland Usuel Rasidance of Decedant 10a, Stata 10b County 10c City Town or Location 10d. Inside City Limits 28a-f show 1 Yes XIX No Director Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? b florns 23a 7108 Stretch Court 21774 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forcas? Black, White, etc. 1 Yas 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: þ 3√ Widowed 4 Divorced White 15. Decedant's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiana. Hygiana. Other then "n Elemantary/Secondery (0-12) College (1-4or 5+) self homemaker permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If from 27 is marked other 1 any Injury or other traumatic event. Its 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be John William Thompson Bessie Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 7106 Stretch Court, New Market, Maryland 21774 Debra Bowers, daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Ramoval from Stata 12/23/99Frederick, Maryland Olivet Cemetery -4 Donation 5 Othar (Specify) 22. Nama and Address of Facility Keeney and Basford Funeral Home 21. Signeture of Funeral Sarvice Licensee MO0999 106 East Church Street, Frederick, MD yun U 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Cerebral Voscalar diseasa or condition rasulting in death) Examiner Examiner physician and s the burial-trans Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated events resulting in daeth) Last Box 68760, Physician/Medical vosculor disesse Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown MELLITUS Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 45 PENTENSION 1 ☐ Yes 2 ₺ No 1 □ Vas 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical Be 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be datamined 3 ☐ Suicida 28e. Place of Injury - Af homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifias (Check only one) 29b. Signature all a sittle of cortifie 29c. License number 29d. Data signed (Month, Day, Year) 026 499 Ky D. 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) PO Box 210, Mt. Airy, Ronald Miller MD MD 2 2 1999 Ragistrar Signatura State

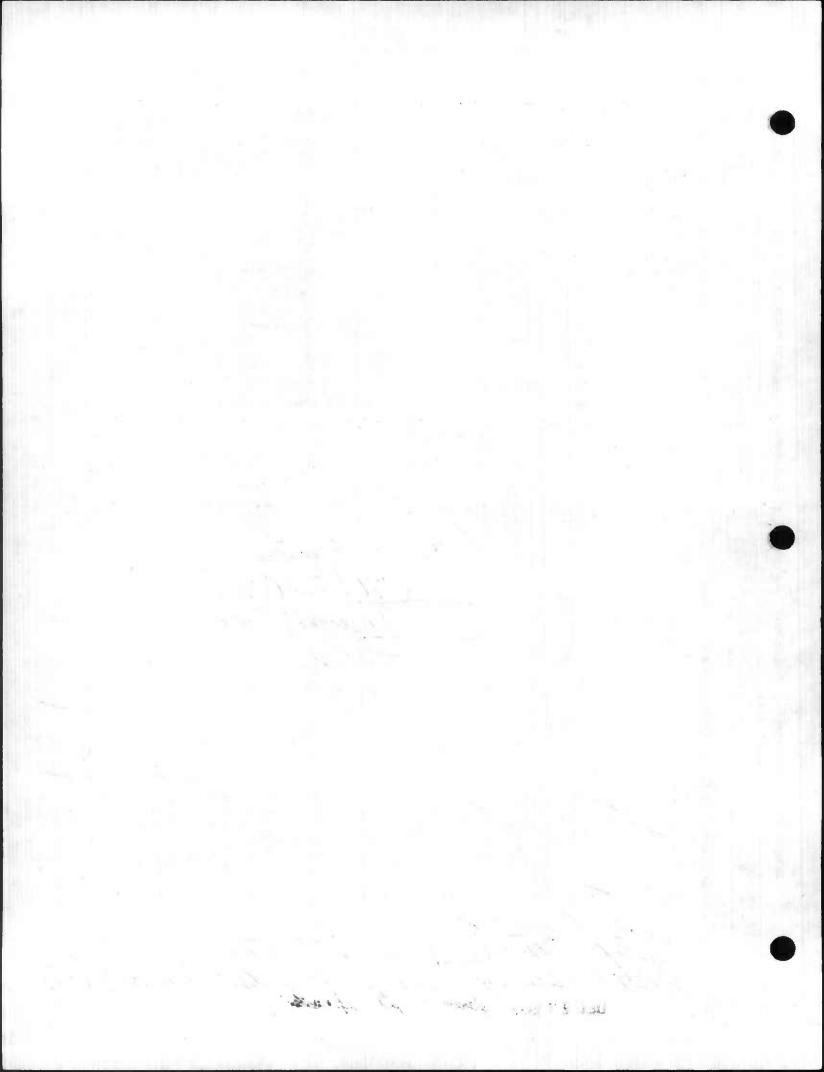
Registrar



# Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

				Certific	ate o	f Death		Reg. No.	99	+2683
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aminer	4a Fecility Name (If not institution,	give street and number	er)			4b. City, Town, or	Location of Deat	h 4c. Coun	ty of Death	
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al	5. Social Security Number	i. Sex 7. 1 ☐ M 2 🛱 F	Age (In yrs. li	Mont	der 1 Yea			th ly, Year)	9. Birthple	ce (State or Foreig
	214-22-1250		72	Yrs.			July 6	, 1927	Maryl	and
	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Location					10	d. Inside City Limits
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Directo		Oru	1							
Ē	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Countr	γ?
Funeral	1620 B Denise	Dr.			210				JSA	
	11. Marital Status	12. Wes Decede Armed Force	nt Ever in U,S s?	S. 13. Wes De	cedent o	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Ra	eck, White, el	
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ı	3 ☐ Widowed 4 ☑ Divorced	Year or Date	\$:						.,. ••1112	
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The second second	17. Fether's Name (First, Middle, La	_				18. Mother's Ne	me (First, Middle		me)	
	John Benson	Humphrey	-			Anna	(nmn) P	owers		
	19a. Informent'a Name/Relationship	(Type, Print)		19b. Meiling Add	ress (Stre	et and Number or R	ural Route Numb	er, City or Tow	n, Stete, Zip (	Code)
	Helen N. Leach/	POA		411 Fore	hand	Ct., Bel	Air. Ma	rvland	21015	
	20a. Method of Disposition		~	ace of Disposition (	Name of		Dete	20c. Location		m, Stete
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MING	resulting in death) Last		come un foi	A	211	0				
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and the same	Pert II. Other significant conditions	contributing to death	but not resu	Iting in the underlyi	g cause	given in Pert I.				the cause of death
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	27. Manner of Beath	28a. Date of It		28b. Time of	28c. In		7			
	1 Partitions 5 Pending investiga		Day Year)	Injury M		Vork?	28d. Describe how injury occurred			
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	4 Homicide determin	building,	etc. (Specify	)	iory, onic		City or To			710010 11011001;
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	30. Name and addgrss of person wi	so completed cause of	death (Item	23a) (Type, Print)	a	245	11	1	1100	1
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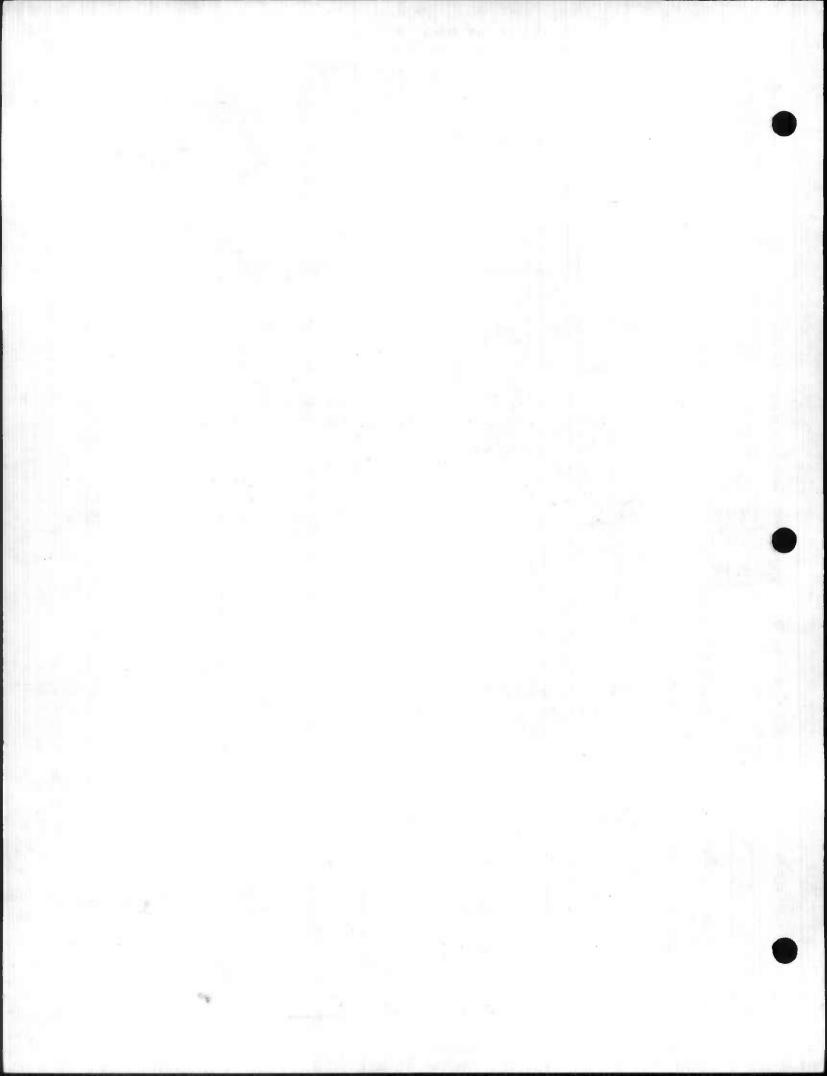
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42684

					Certificat	e of	Death			Reg. No.			
		1. Decedent's Name (First, Middle, L.	ast)						2. Date of Dea	nth Dey	Vaar	3. Time o	of Deeth
Ð	Physician /Medical	MARIE E.	ZEBRO	OSKI					Decemb	er 18,	1999	7:00	AM
	Examiner	4a Facility Name (If not institution, gi	ve street and number)				4b. City, To	own, or Lo	ocation of Death	1	y of Death		
		Frederick Memori	ial Hospital				Fred	ericl	k	Fr	ederi	ck	
	Funeral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birtl	Months	r 1 Year Days	If Under Hours	24 Hrs.	8. Date of Birt	h v. Year)	9. Birthp	lace (State	or Foreign
ı.	Director	215-34-3710 May 26, 1937											
	pu *	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						- 1	0d. Inside C	"its Limite
	aho aho												2 No
	vith the Marie or 28a-f a be notified	Maryland Freder	rick	Woods	sboro 101. Zig	Cada				10g. Citizen of	Milh ed Court		
	with with	10132 Woodshord	Pond			2179	0			United			
	es 23	10132 WOOds DOT	12. Wes Decedent Ev	ror in II S				iain? (Sn			ce · Americ		
Maryland 21215-0020	72 hours after death with the Maryland natural, or thems 23s or 28s-f show diest Examinar must be notified at sted by Funeral Director	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			Specify.		pecify Yes or No- Pican, etc.)  14. Race · Ame Bleck, White Specify: Wh			etc.		
0	"natural", esien En	15. Decedent's E			Decedent's Usu			-		16b. Kind of E	3usiness/Inc	Justry	
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yia	De As S	Horace Smith					V	iole	t Clary				
a	& DEE	19a. Informant's Name/Relationship	(Type, Print)						al Route Numbe	er, City or Town	n, State, Zip	Code)	
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Ore	Pages 1 and ment of Healt ant: if ham 27 lury or other	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removel from State	20b. Place of cemetery	Disposition (Na. crematory or o	me of other pla	ce)	ir	Date 21	20c. Location			
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Baitimore,	permit. Pages 1 Department of H Important: If Ital eny Injury or ott pncs.	21. Signature of Eurotral Service Lice	nsee		22. Name er			Sta	auffer : ke, Fred	Funeral	Home	s, P.	Α.
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	Physician	shock, or heart failure. List only	y one cause on each line								i	Intervel Be Onset and	
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	Examiner	disease or condition resulting in death)	a	Spirate un to (or as a c	7	211	wee				1	- 11	MONTS
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o,	Ex Ex	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		arian		co						3 ye	0.43
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	et the death ce d by the attendi etached for use Physician/	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying (	cause giv	ren in Pert	I.	23b. Dld 1	obacco use c	ontribute to	the causa	of death?
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		30. Name and address of person who		th (Item 23a) (1	(ype, Print)	2	ALA)	AUC	KIMD	21701			
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State of Maryland / Department of Health and Mental Hygiene 99 42685

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29a. Cartifiar 1 XCertifying	Physician: To the be	st of my knowle	dge, death	occurred at the tim	ne, date and place	and due to the	cause(s) and ma	anner as stated.	
(Check only 2 Medical E	xaminer: On the basis	s of axamination	n and/or invi	astigation, in my of	pinion, death occu	rred at the time,	, date and place,	and due to the cau	50(S)
29b. Signetyre end title of certifiar						,	29d. Date signe	d (Month, Day, Yea	ir)
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	Immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  25. Was case referred to medical examiner? 1   Yes 2   Yes 27. Manne of Death 1   Naturat   5   Pending investig   28. Cartifier (Check only one)   2   Medical E	Immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  25. Was case referred to medical examiner?  1	Immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. 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Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying in death of the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying in death but not resulting in the underlying  Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives a saminar?  1 Natural 1 Natu	23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac medical causa (Final disease or condition resulting in death)  Sequentially list conditions, and address of person who completed cause of disamples.  25. Was case referred to medical axaminar?  26. Place of Death 1 (Month, Day Year)  27. Mannard Death 1 (Month, Day Year)  28. 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License number 29c. License number 29c. License number 29c. Data filled (Month, Day, Year)  32 Register's Signeture 32 Register's Signeture 33. Data filled (Month, Day, Year)  32 Register's Signeture 33. Data filled (Month, Day, Year)  34. Data filled (Month, Day, Year)  35. Data filled (Month, Day, Year)  36. Register's Signeture 36. Data filled (Month, Day, Year)  37. Register's Signeture 38. Data filled (Month, Day, Year)  38. Register's Signeture 39c. Signetyre 39	23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and a subsection of each fine. List only one cause on each fine.  Immediate Cause (final disease or conditions) a	Inflaved late Cause (Final death)  a.	

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Violet Blanche Adams December 5:42 m /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Asbury/Solomans Retirement Center Solomans Island Calvert 8. Data of Birth (Month, Day, Year)
Nov. 17, 1 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1 □ M 2 🖺 F Months Days Hours Yrs. 1910 Virginia 578-22-4026 89 Usual Residence of Decedant 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 X Yas 2 No Director Maryland Calvert Solomans Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11750 Asbury Circle - Suite 104 20688 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, Whita, atc. 1 Nevar Married 2 Married I ☐ Yas 2 ☒ No If Yas, Giva 1 ☐ Yas 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Secretary U.S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Be William Thrift Nora Lee Hale 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Marjorie R. Hay - Daughter 42 Rabbit Run Lane, Berlin, Maryland 21811 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of 20c. Location - City or Town, Stata cematary, crematory or other place) 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery 01/06/00 Suitland, Maryland 22. Nama and Addrass of Facility
Gasch's Funeral Home, P.A. 21. Signatura of Funaral Sarvica Licensaa 4739 Baltimore Avenue, Hyattsville, MD 20781 acc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death Immediata Causa (Final Preumonia As piration disaasa or condition resulting in daath) Due to (or as a consequence of) Physician/Medical Examiner Dementia Sequentially iist conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa referred to medical 26. Pleca of Death (Check only one) Other: Nursing Homa 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 ☐ Yas 2 No Certification: To Deta of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation Neturel 1 Yas 2 No 2 Accident 6 ☐ Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida to the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) end mannar as stated.

2 ■ Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mannar stated. Medical 29a. Certifiar (Check only one) 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Dav. Year) 047610 January 4, 2000 30. Nama and address of person who complated causa of deeth (itam 23e) (Type, Print) David J. Tardio, M.D. Route 4 Patuxent Plaza, Solomans, Maryland 20688

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director: After this certification by the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director directors and the funeral directors are directors.

**Funeral** 

Director

Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health end Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a any injury or other traumatic event, the Medical Examiner must be notified and ponce.

Physician /Medical

Examiner

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signed b

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P.O. Box 68760.

Records,

Division of Vital

State Registrar 31. Data filed (Month, Day, Year) JAN 0 6 2000 32. Registrar's Signatura

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## Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day B1665 Month **Physician** MAST 1999 December 31 10:27AM /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Days 1□M 2♥F Washington DC 578 24 0995 74 Yrs. Director Usual Residence of Decedent The Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits show 1 Yes 2 No Director Maryland Prince George's Temple Hills 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e or 5717 Colon Terr. 20746 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Merried 2 Married hours after ☐ Yes 2 No f Yes, Give 8 specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Statistician Census Bureau 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Ira E. Biggs Evla Snyder 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) nt of Health a If them 27 is or other tre 11805 College View Drive Wheaton, MD 20902 Iris Webber 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Jan. 6,2000 Burial 2 Cremetion 3 Removel from Stete Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 21. Signature of Fundam Service License 22. Name and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 ions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, tause on each line. 23e. Pen 1. Enter the diseese, or compleshock, or heert feilure. List only of Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel diseasa or condition resulting in deeth) /Medical Examiner Examiner CALDIOUKSCUM The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): ed for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 signed by the 1 Yes 2 No 3 Probably 4 Unknown م Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes NA No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: funeral director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20€No 1万 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Cartifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 OLD LINE CENTER WALDONE, MID WISETSK 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 0 7 2000 Registrar

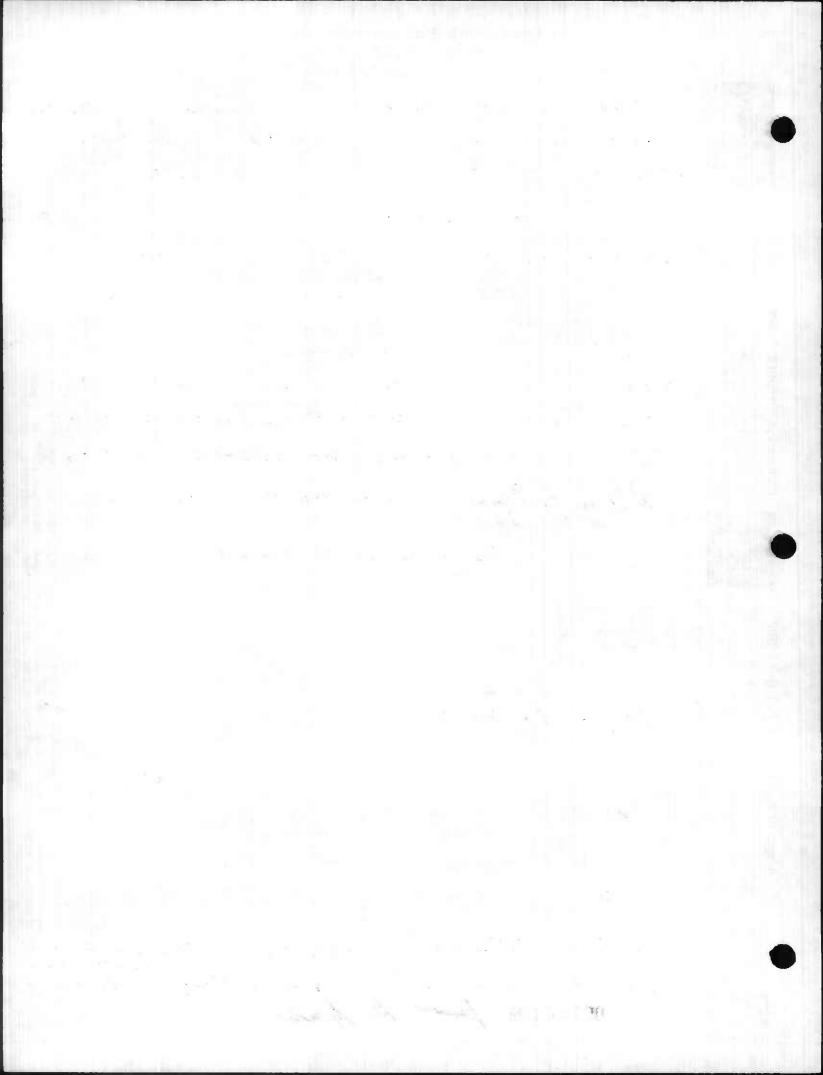
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Q Q

42688 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Death 3. Time of Death **Physician** MILDRED PAULINE BLOOM 1999 December 25 5:20 p.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Ginger Cove Health Center Annapolis Anne Arundel Undar 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 90 Yrs. If Under 1 Year Birthplace (Steta or Foreign Country)
 MN 8. Date of Birth (Month, Dev. Yaer) **Funeral** 1□M 2**[**]F Months Deys 471 32 1326 July 29, 1909 Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 Yas MNo Annapolis Anne Arundel Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code USA 21401 4000 River Crescent Drive Funeral Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) Rece - Amaricen Indian, Black, White, etc. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: white þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. X-Ray Technician Health Care 12 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) bernit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Binder Amelia Hammerlund C George 7 is marked traumetic a 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Relationship (Type, Pnint) 219 Stony Hill Rd., Fredericksburg, VA 22406 Paul T. Nast/son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donetion 5 Other (Specify) Friendship, MD Friendship UM Church Cem 12-30-99 21. Signature of Funeral Service Licensae 22. Nama and Address of Facility ellian Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Heart Failure Immediate Cause (Final disease or condition resulting In deeth) /Medical Conjective Examiner Due to (or es e consequence of) Examin The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): USB as t attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? certificate hes b lirector, page 2 s 1 Ves 2 No 1 ∏ Yes 2 ∏ No 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending Investigation efter death. 1 Tyes 2 No 2 Accident ector: by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours efter Funeral Dire letely filled in b Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number melans 2003 hedre Parry 2,451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 32. Registrar's Signature State DEC 3 0 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 30, 1999 Month **Physician** William . Baker 8:06 P.M. December /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 45939 Halsey Court California St. Mary's If Under 1 Year | If Under 24 Hrs. | Hours | Min. 6. Sex 1 ☑ M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 57 218-38-6533 Vrs Director 1942 Maryland Usuai Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 TYes 2 No St. Mary's Maryland Director California 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? tem 27 is marked other than "natural", or items 23s or other treumstic event, the Medical Examinar name be a 45939 Halsey Court 20619 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s any Injury or other treumstic avant Funeral 12. Wes Decedent Ever in U,S.
Aspned Forces?
1 © Yes 2 □ No 1963 —
If Yes, Give
Yeer or Detes: 1966 Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Van Driver Tri County Youth Serv. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Harold. Baker Sarah Evelyn 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sarah Evelyn Hewlett/Mother P.O. Box 149 Dameron, MD 20628 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removei from State 1/6/00 4 ☐ Donetion 5 ☐ Other (Specify) St. Peter Claver Cem. St. Inigoes, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signeture of Funeral Service Licensee Glacker 9. Sewall 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or compilectione that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or haart feilure. List only one cause on each line. **Physician** a. Resp Que to (or as a consequence of): /Medical Immediata Cause (Finel disease or condition resulting in deeth) Examiner Carodiac awest attending physician and for use as the burial-transit Sequentielly list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initieted evants resulting in death) Last Dua to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Metastatic CANCER Physician/Medical Due to (or es e consequence of): Liver met Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sigmoid CANCEN þ 24b. Ware autopsy findings avellable prior fo completion of cause of death? 24a. Wes an eutopsy performed? Completed peed Joundia 1 Yes 20No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Placa of Deeth (Check only one) Hospitei: Other: 4 Nursing Home SP Residence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menper of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 5 Pending 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be datarmined 3 Suicide 28e. Piece of Injury - Af homa, ferm, atreef, fectory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to certifying Physician: To the best of my knowledga, deeth occurred et tha tima, data and piece, and due to the ceusa(s) and mannar as atated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at tha time, data and piece, and due to the cause(s) end menner steted. 29a, Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 1 - 3 - 2000 MD 50290 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Dhiren Shah, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra s Signeture State JAN 0 3 2000 Registrar

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Section 1

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Funerai		5. Social Security Number	6. 5	ex MM 2□ F	7. Age (In yrs	s. last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth a.v. Year	-)	9. Birthpi	ace (Str	ate or Foreign
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Baltimore, Maryland 21215-0020  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumetic event, the Medical Examine must be notified at once.	Funerai	1 ☐ Never Married 25	Married	Armed F	orces?		f Yes, spe	cify Cube	en, Mexican	, Puerto	ecity Yes or No Rican, etc.)		Blac	ck, White,	etc.	
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Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. T is marked other than "natural", or traumetic event, the Medical Event traumetic event, the Medical Event.		19a. informant's Name/Rel	atlonship (	Type, Print)		19b. Mailir	ng Addres	s (Street	an <i>d Numb</i> e	er or Ru	ral Route Numi	per, City	or Town,	State, Zip	Code)	
and and lealth man		Patricia A.	Baker	u (wif					et, S	E. V	Vashing					
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Baltimore, permit. Pages 1 an Depertment of Heal Important: If item 2 any injury or other		21. Signature of Funeral Se	rvion	1000	12.				ss of Facilit		, 5538	Mar1	horo	Dile		
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Physician /Medical Examiner	L	Immediate Cause (Finel disease or condition resulting in death)		a. E		ge Rena:									Unset a	ind Death
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18760, cete be executed physician and the burial-transit	dical E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	c. D	iabetes	3										
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DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 12:03 PM DECEMBER Samuel Calvin Boothe 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Doctor's Community Hospital Lanham Prince Georges If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 7€M 2□ F Months Deys 67 229-40-1812 Dec 5, 1932 VA Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9410 Franklin Ave. 20706 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 100 Yes 2 D No If Yes, Give Yeer or Dates: Korea 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 ☐ (No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Korea 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondery (0-12) College (1-4or 5+) Coleman-Woods Const. Carpenter 9 yrs. 17. Father's Name (First; Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Walter Boothe Virgie Belcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 9410 Franklin Ave. Laura F. Boothe (wife) Seabrook. MD 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery Cheltenham. MD 21. Signeture of Juneral Service Licensee 22. Name and Address of Fecility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, 20706 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) END STAGE CONGESTIVE HEART FAILURE

**Physician** /Medical Examiner

Box 68760.

P.O.

Records,

of Vital

Division

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or Attending Physician:

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24 hours a Funeral C Hospital

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1 and 2 should be Health and Mental

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

Physician/Medical by Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

CAN DIS MY OF ATTY Due to (or as a consequence of): ANTERY

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23h. Did tohacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

PERCHPIDEMIA

24a. Was en autopsy performed?

26. Place of Death (Check only ona)

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yes 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Dete of Injury (Month, Day Year) 5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Maturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

MO mas

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Aroer S. Rao Lanham Md 20206 8100 Good Luck Rd Suite 302 31. Date filed (Month, Day, Year)

28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

JAN 0 5 2000

6 Could not be

32. Registrer's Signature

600 . . . **NA**1.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 259 DECEMBER 26,199 Connie L. Bell /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner PHINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TF Months 577-52-2623 July 4, 1927 Director North Carolina Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Prince Georges' Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20710 United States 5999 Emerson Street deeth Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iten eny Injury or other traumatic event, the Medical Exertical eny Injury or other traumatic event, the Medical Exertical Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: by Black. 3 d Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Bazemore Bertha Bazemore 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Bell, Jr./ Son 4826 Russell Avenue, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 1-4-00 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service (Censell 22. Name and Address of Facility Lincoln Funeral Home Bladensburg Rd., Brentwood, Maryland 20722 Approximate interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical HYPERTENSIVE ARTBRIOSCUBROTIC CARDIOVASCULAR PISEARE Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of): 80 950 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown PLABETES MELLITUS Records, à 24b. Were autopsy tindings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 hes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2DER/Outpatient 3□ DOA 1 Inpatient this funeral 28e. Date of injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 8 To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and majorier stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 23a) (Type, Print) PRIVE GOLLE CHEVERLY MARYLAND 32 Registrar's Signature 31. Date fil-State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 9 4 2 6 9 3

				Cei	rtificate of	Death	Re	eg. No.			
	Physician	1. Decedent's Name (First, Middle, L Phillip Dale Bar					2. Date of Deat Decembe		9 <del>9</del> °	3. Time of Death 10:30 AM	
	/Medical Examiner	4a Facility Neme (If not institution, gi Anne Arundel Med	y of Death Arundel								
	Funeral Director		Sex 7. Age (In 55	yrs. lest birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, Aug 13	,1944	9. Birth Cou Ariz	place (State or Foreign ntry) Ona	
	2	Usual Residence of Decedent									
	anyler der	10a. Stete 10b. County		:. City, Town or Lo	cation					10d. Inside City Limits	
	Series Se		George's 1	Bowie						Yes 2□No	
	Oire	10e. Street and Number			10f. Zip Code	1.5	1	0g. Citizen of			
	ath v	3911 York Lane	T		207			United		can Indian,	
020	72 hours after death with the Maryland natural; or items 23s or 25s-f show sical Examinet must be notified at seed by Funeral Director	11. Maritel Stetus  XV Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?  1 ☐ Yes ②∭No If Yes, Give Yeer or Dates:		13. Wes Decedent of Hispanic Origin? (Specif Yes, specify Cuben, Mexican, Puerto R     1 ☐ Yes ※ No Specify:			Ble	ck, White,	ite, etc.	
9-0	2 ho	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation during most of work	kina	16b. Kind of B	usiness/ir	idustry	
21215-0020	within then then then then then then then the	(Specify only highest gr Elementary/Secondary (0-12) 12	College (1-4or 5+) 5+	Sale	DO NOT use retin	ed)	Ving	Self H	Emplo	yed	
Pu	be filed tal Hygi d other event, the	17. Father's Name (First, Middle, Las					ne (First, Middle, I		ne)		
Val	should be not marked umartice	Lewis Dale Barto	n			Susan I	rene Pat	terson			
, Maryland	0 0 0	19a. Informant's Name/Relationship Lewis Barton/Fat	(Type, Print) her			ne Bowie,			, Stete, Zi	p Code)	
Baltimore,	Pa Int	20a. Method of Disposition  XX Burial 2 Cremation 3 [ 4 Donation 5 Other (Special	Removal from State	Db. Place of Dispo cemetery, crea Lakemont	osition (Nome of metory or other plane) Memoria	Gardens	12/20/	20c. Location Davids			
Balt	permit. Pag Department Important: I eny Injury o pncs.	21. Signature of Creral Service Lice	iller	R	6000 Ann	Evans Fu	ad Bowi	e, MD	2071		
	Physician /Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aplications that caused the cone cause on each line.			ing, such es cardiac		est,		Approximate Interval Between Onset and Death	
	SEASON MESSA	Toodking in douting	Bue	to (or as a conse	(to estreup	>				110-00%	
	nine		b. 150	C/6/10	1 JEK	2515			-	1 11-6-19	
68760,	certificate be assecuted right physician and use as the buriel-transit and wheeltransit and edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	s	to (or es e consec O)DO/ to (or as a consec	Absc	CT				1 month	
Box 68	2 5 5	resulting in death) Last	d						i		
	deat death ed for	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause g	jiven in Pert I.	23b. Did to	bacco use co	ontributa	to the cause of death	
ords, P.O. Box requires that the death cer een signed by the attendin hould be detached for use eted by Physician/N	Digbelfs 10 YOS 2DAGO							3□ Pro	obably 4 🗆 Unknow		
0 - 0 -							24e. Wes a perform		a	Vere eutopsy findings vailable prior to ompletion of cause f death?	
m	ysicien: The law s certificate has director, page 2 To Be Comp						1 🗆 Y	es 20No	1	☐ Yes 2☐ No	
Vital	certificate rector, pag	25. Was case referred to medical	/			26. Place of Dea	ith (Check only or	10)			
f V		examiner? 1 Yes 2 No	Hospital: 1 inpatient	2 ER/Outpatie	nt 3 DOA	ther: 4 Nursing H	ome 5 Reside	ence 6 🗆 Ot	her (Spec	ity)	
ion of	Attending Physical deeth.  Total that the this by the funeral diffication: Total	27. Manner of Death  1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Yea	28b. Time of Injury					rred		
Division	Date of the	3 ☐ Suicide 6 ☐ Could not determined	286. Place of injury -	28e. Place of Injury - At home, farm, sireet, factory, office building, etc. (Specify)  28f. Location (Street and Nun City or Town, Stete)						ral Route Number,	
	To the Hospital within 24 hours within 24 hours completaly filled	29a. Certifier   1   Certifying P   Check only one)   2   Medical Exa	hysician: To the best of my miner: On the basis of exar and menner stated.	knowledge, deet mination and/or in	h occurred at the vestigation, in my	time, date and place opinion, deeth occu	, end due to the c rred at the time, d	ause(s) and m late and piece	anner as , and due	stated. to the cause(s)	
	To the vithing To the comp	29b. Signature and Affle of certifier	the mo		29c. Licer	nse number 7445	2	9d. Date sign	ed (Month	Dey, Year)	

Registrar

31. Date filed (Month, Dey, Year)

JAN 0 3 2000

DHMH 16 Rev 6/95

JAN 0 3 2000 See-

State of Maryland / Department of Health and Mental Hygiene

Department	of Freakitt and	Wieman 11
Cartificata	of Dooth	

Certificate of Death Reg. No.

Physician /Medical
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last) MARY GLENDORA **BLACKMAN** 4a Facility Name (If not institution, give street and number)

2. Date of Death 31 December

7:45 AM

**Funeral** 

5. Social Security Number 067-70-2011 **Usual Residence of Decedent** 

1 □ M 2 K F

Magnolia Gardens Nursing Home

If Under 1 Year Months Deys 7. Age (In yrs. last birthday)

10f. Zip Code

20721

If Under 24 Hrs. Hours Min.

Lanham

4b. City, Town, or Location of Death

8. Dete of Birth (Month, Day, Year) April 25, 1914

Prince George's Birthplace (State or Foreign Country) Guyana, So. America

10d. Inside City Limits

1 X Yes 2 No

Director

28a-f show must be o filed within 72 hours after ò "nathural" Hygiene.

21215-0020

Baltimore, Maryland

Department of important: If any injury or

**Physician** 

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital Physician:

Division

/Medical Examiner

and

physician

the

Examiner

Physician/Medical

þ

Completed

Be

Directo Funeral þ Completed Pages 1 and 2 should be fit ment of Health and Mental H lant: If ham 27 is marked oth lary or other traumatic even Be

10a. State 10b. County Maryland Prince George's 10e. Street and Number 11550 Waesche Drive 11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed)

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Ter can

85

10c. City, Town or Location

Mitchellville

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

1999

4c. County of Death

Elementary/Secondary (0-12) 12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker

16b. Kind of Business/Industry Private

10g. Citizen of What Country?

U.S.A.

18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown

17. Father's Neme (First, Middle, Last) Aubrey Bishop

19a. Informant's Neme/Relationship (Type, Print) Clem Jones/Daughter

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 11550 Waesche Drive, Mitchellville, Maryland 20721

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetery or other plece)
Harmony Memorial Park

01/03 2000

20c. Location - City or Town, Steta Landover, Maryland

4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses

23a. Pert1. Enter the diseaset, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one cause on each line.

J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Approximate Interval Between

Immediate Cause (Finel disease or condition resulting in death)

Due to (or as e consequence of

Due to (or as a consequence of)

Onset and Deeth

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes an autopsy performed?

24b. Were eutopsy findings available prior to 1 □Yas 2 □ No

25. Wes casa referred to medicel examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day Year)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29e. Certifier

\*\*Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signetum and the of certify

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JAN 0 3 2000 32. Registrar's Signature

m.D 4000 Mitchelle

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

To the Hospital of within 24 hours at To the Funeral D completely filled in

this

al or Attending F after death.

funeral

the

3

filled in

Medical Certification: To

(Check only one)

27. Manner of Death

1 Alatural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

6 Could not be determined

5 Pending investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □ Yes 2 □ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Deeth (Check only one)

29c. License number

RD Bowil, MD 207/6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** VeRA CHANS

4a Facility Nama (If not institution, give street and number) 18:05 PM December 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultmore System Maryland Medical University Baltimore City Hours Min. Mayorth Say, Year) 29 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 243-42-9601 1□ M 2√2 F 70 Yrs Director North Carolina Usual Rasidence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show unt be notified at Baltimore Catonsville Md. 1√Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 IISA 2210 Frederick Rd. Funeral Berna 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, and Mental Hygiene, natural, or lien is marked other than "natural", or lien raumatic event, the Medical Examiner. A BHACIR WITH MIC. 1 Never Married filed within 72 hours after 1 ☐ Yas 2♥ No If Yas, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: INDIAN à 3 Widowed 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Press Operator Waverly Publishing Co. 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) permit. Pages 1 and 2 should be file.
Department of Health and Montal Hy
Important: If Item 27 is marked other
any Injury or other traumatic event Be Edna Locklear Jasper Bell 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $SAME \quad AS \quad 10e$ 19a. Informant's Name/Relationship (Type, Print) Chavis / spouse Eli 20c. Location - City or Town, Stata 20a. Method of Disposition 20b. Place of Disposition (Nama of Date comatary, crematory or other place)
LUMBEE MEMORIAL GARDENS DEC. 31,1999 LUMBERTON, NC Nation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funaral Sarvice Lightness 16000 Annapolis Rd. Bowie Maryland processed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. Approximete Intarval Between Onset and Death **Physician** /Medicat Immediata Cause (Final Circhosis disaasa or condition rasulting in death) Examiner Dua to (or as e consequence of) Examiner C 4/3 intection Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disease or injury that initiated avents resulting In death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of): 88 been signed by the should be detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Records. 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 2500 1 Yas 2 No Division of Vital or Attending Physician: funeral director, 25. Was case rafarred to medical examinar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No edicai Certification: To 1 Inpatiant 2 ER/Outpetient 3 DOA this 27. Menner of Death 28h. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 1. Seletural 5 Pending s after death. 1 Yes 2 No invastigetion 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28a. Placa of Injury - At homa, larm, street, lactory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Data signed (Month, Day, Year) 29b. Signature age title of certified 29c. License number 13363 December 27. 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) Braun Martin 22 5. Greene 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JAN 0.3 2000 Registrar

DHMH 16 Ray 6/95

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33H 13 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month NUN BOBBY RAY Crawley Dec 30 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Serours Baltimore HOSP HAL If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 114M 20 F Yrs. Feb.26,1938 Halifax, Va. -48 - 5970Usual Residence of Decede 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore, Md. 10a Street and Number 10f. Zin Code 10g Citizen of What Country? 21712 St.James Terrace #827 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Never Married 2 Merried 1 Yes 27 No If Yes, Give Year or Dates: Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Presto Plate 10th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Okary Adams Eddie Lee Crawley 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Tanners Way #H Richmond, Va. 23224 Louise McCoy(Sister) 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Cross Rd. Church 1-5-00 Turberville, VA 4 ☐ Donation (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
Dunn & Sons Funeral Service 5635 Eads St, N.E. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Cause (Finel 30 minutes CALDIAL ArryThmin disease or condition resulting in death) Due to (or as a consequence of) STENOSIL Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL Disease 24b. Wera eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA

Examiner attending physicien and for use as the burlei-transit Box 68760. Division of Vital Records, P.O. 30

**Physician** 

/Medical

Examiner

Md.

Director

Funeral

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Completed

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**Funeral** 

Director

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the Maryte

72 hours after

Hygiene.

permit. Pages 1 and 2 ahouid be filed wit Department of Health and Mental Hygens Important: If New 27 is marked other that any Injury or other traumatic event, that otics.

**Physician** /Medical

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed To this To the Hospital or Attanding P. within 24 hours after death.
To the Funeral Director: After ti completely filled in by the funeral Aftert

DroBetes mellitus Paripheral Vascular 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)



GREENWELL

Dreen well

29c. License number 1)34334

29d. Dete signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

315 N. CALVERT ST. BOLLINGER M

State Registrar

29b. Signature and title of certifier

32. Registrar's Signeture

5005 - 9 MAL

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Dec 30, 1999 Mary Elaine Cleaver 8:00 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 24 Hrs. Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Days Hours 1□ M 2以 F Months 73 Yrs. 579-30-5356 ebruary 25,1926 Michigan **Usual Residence of Decedent** 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Charles Port Tobacco 1 Yas 2X No Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7385 Simms Landing Road 20677 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Marriott Corporation Accountant 17 Father's Name /First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Ira Edward LaLonde Mary Bessie Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Don H. Cleaver / Husband 7385 Simms Landing Road, Port Tobacco, Maryland 20677 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 01/05/00 Brentwood, Maryland 22. Name and Address of Fecility Gasch's Funeral Home, P.A., 21, Signature of Funeral Service Licensee tle 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION INTERSTITEAL LUNG DISEASE 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? EMPYEMA 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

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Completed

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**Funeral** 

Director

r than "natural", or flams 23s or 28s-f the Medical Examiner must be notifie

72 hours after

permit. Pages 1 and 2 should be filled within: Department of Health and Mental Hygero, important: if item 27 is marked other than "1 any injury or other traumatic event, the Mad

Baltimore, Maryland 21215-0020

physician s the burial Physician/Medical # After

Division of Vital Records, To the Hospital
within 24 hours a
To the Funeral
completely filled 20 State Registrar

ğ Completed 8 2 at or Attending attendesth.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

🗷 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

D-26064

12-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anmangandla Vidyasagar, M.D. P.O. Box 282 Charlotte Hall, MD 20622

31. Date filed (Month, Day, Year)

JAN 0 4 2000

32. Registrar'a Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend # 31. P.G. Co. 1-4-00 Cr 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day December 30 **Physician** Bernard Francis Dent 9:53AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Feb. 1, 1913 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days 1₩ 2□F Hours 578-01-2955 Yrs. 86 Maryland Director Usual Rasidanca of Decedant the Meryland 10b. County 10c. City, Town or Location 10a. Stata 10d. Inside City Limits mart be notified at 1 Vas 2 No Director District of Columbia Washington 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 4537 Eads Place, N.E. 20019 United States Nerns 23a 12. Was Decedanf Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status o filed within 72 hours after de la Hygiene. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black à 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Meniel Hygiens important: If item 27 is marked other tha any Injury or other treumatic event, the 1 page. Box Maker Private 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) James D. Dent Eliza Blair 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) William E. Christian - Son 14 Scheerer Ave., Newark, N.J. 07112 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Forest Hills Cemetery 1/8/2000 4 ☐ Donation 5 ☐ Othar (Specify) Clinton, MD 22. Name and Address of Facility of Punaral Sarvice Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Wor SVI inter the disease, or complications that caused the death. r heart failure. List only one cause on each line. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final a rounce diseasa or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner that the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of Box 68760, Physician/Medicai Dua to (or as a consequence of) P.O. Part II. Other algrificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Melletus 1 Yes 2 No 3 Probably 4 Unknown DD refiles Records, À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sutopsy performed? Completed 1 Yas 2 No 1 Yas 2 No of Vital 25. Was casa rafarrad to medical examinar? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 10 1 Yas 2 No this After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury af Division or Attending 5 Pending Invastigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fund 1 Yas 2 No 2 Accidant 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homlcide 29a. Cartifiar 1🖄 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) end mannar as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number 20129 cet 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) A. A. CHA CKO MD, 7610 CO 80011 AVE-# 390, Takeme. Pask. MD 20912

DHMH 16 Rev 6/95

Registrar

31. Dafa filed (Month, Day, Year)

G. Spale

32. Regisfrar's Signafura

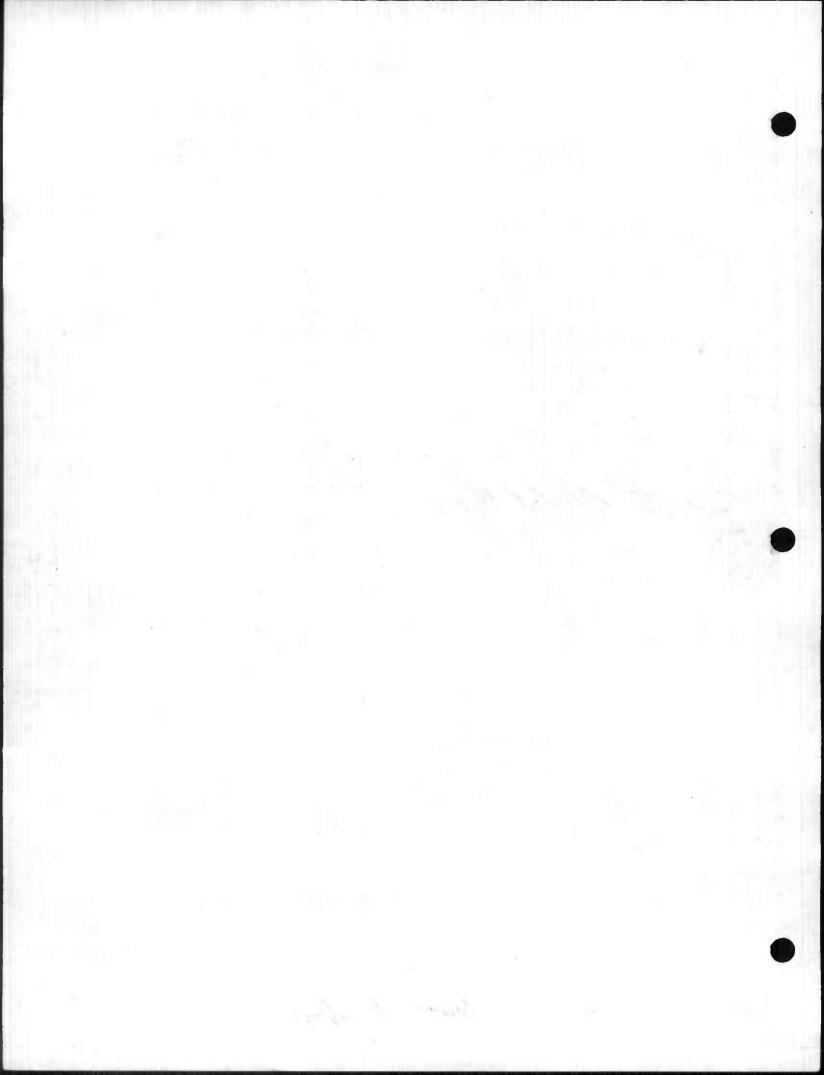
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ( Michael Jeffrey Dickens Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Jeffrey 31, 1999 4c. County of Death lichae December 31 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Bd If Under HMOVE CITY SHOPKINS
Security Number 6. Sax If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F none Yrs. Director MD Usual Rasidence of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Herna 23a or 28a-f show the Medical Examiner must be notified at MD Prince Frederick Director Calvert 1 ☐ Yes 2√XNo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 108 Helena Drive 20678 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U.S. Armed Forcas? 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. be filed within 72 hours after 1€ Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry : If item 27 is marked other than or other trainment. Elementery/Secondary (0-12) Collega (1-4or 5+) 0 none 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Jeffrey Alan Dickens Angela Lynn Sigona 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Jeffrey A. Dickens (father) same as 10 above Place of Disposition (Nama of cematary, crematory or other p 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or page. Southern Mem. Gardens 1-4-00 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Rausch Funeral Home, Owings, MD 20736 III. Enter the disease, or complications that causes the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaese or condition resulting in death) Examiner Examiner physician and the bunat-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 21210 1 Yas 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas No Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Natural 2 Accident 5 Pending 1 Yes 2 No death. invastigation 24 hours after deat Funeral Director: 6 Could not be datamined 3 Suicida 28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in Certifying Physician: To the best of my knowledga, daeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of could person who completed cause of death ([tem 23a) (Type, Print), 32. Registrar State 2000 04 Registrar



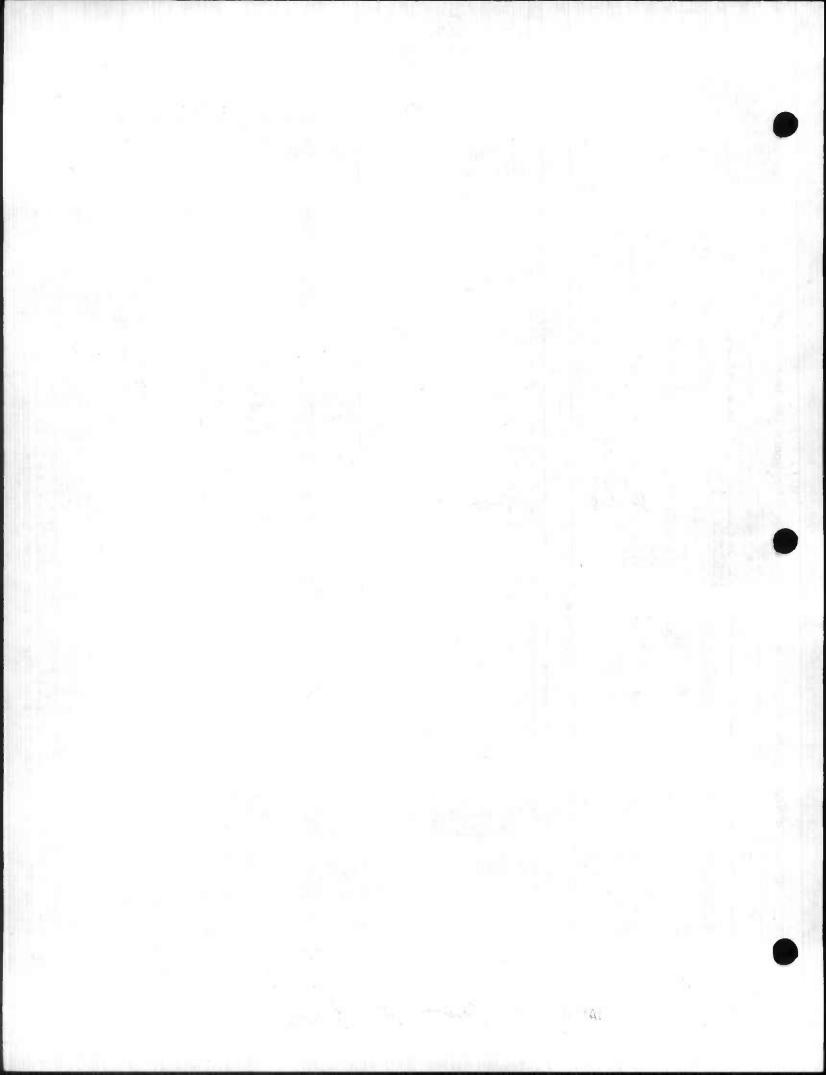
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_ Administ	Civista Medical Ce	nter			LaPI	lata		Ch	arles	
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Attention plants with the funeral Medical Certification.		ner: On the besis of examine and manner stated.								
withing To the comp	29b. Signature end title of certifier			29c. L	icense number		1	29d. Data signe		
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	30. Neme and address of person who co	mpleted cause of death (Iter	n 23a) (Ty				Road, S			
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State	31. Date filed (Month, Day, Year)  JAN 0 4	32. Registrar's Sign	ature		book					
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Vale 9, nia Debiey Baitimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 30, 1999 **Physician** 0014 Ervin DeVere Ellison III /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WASHINGSTON FORT WASHINGTON HOSP ITAL PRINCE GEOKGES If Under 24 Hrs. 8. Dete of Birth
Hours | Min. (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F Months Director 126-07-9362 78 June 27,1921 New York Usual Residence of Deceden the Maryland 10a State 10c City Town or Location 10d. Inside City Limits 10h Counts 7 is marked other than "natural", or frams 23a or 28a-f ahow traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince Georges Fort Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2104 Trafalgar Dr. 20744 USA death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or and of Health and Mental Hygiena. Int: If Nem 27 is marked other than "natural", or Nem All Yes 2 No WWII & Yes, Give Vorea-1981 1 ☐ Never Married 2 ☒ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Military Chaplain Federal Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17 Father's Name (First Middle Last) Ervin DeVere Ellison II Leora Leonard 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lenore W. Ellison/Wife 2104 Trafalgar Dr., Ft. Washington, MD 20744 other t 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 8 1 ☑ Buriet 2 ☐ Cremetion 3 ☐ Removal from Stete Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 1/11/2000 Arlington, VA 22. Name and Address of Facility 21. Signature of Funeral Service Lic George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final . ARTERUSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Examiner physician and the burial-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 □ Yes 2 □ No 1 ☐ Yes certificate Division of Vital i or Attending Physician: aftar death. Director: Aftar this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Ves 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Mapner of Death 28b. Time of 28d. Describe how Injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Mospital 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the To the To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signa DECEMBER 31, 1999 (Itom 33a) (Type, Print) GOLLE HOSPITAL ORNE, CHEVEKLY MARYLAND 20785 3001 31. Date filed (Month, Day, Year)
JAN 0 3 2000 Registrar's Signature

Registrar **DHMH 16 Rev 6/95** 

State

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day **Physician** EdMONDS 1050 AM SEVERLY DECEMBER 26 1999 /Medical 4a Facility Nama (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HEARTLAND OF HYATTSVILLE PRINCE GEORGE HYATTSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 15 M 20 F 79 Yrs. Director 578 12 9140 3/26/20 PACES VA. Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 □ No PRINCE GEORGE HYATTSVILLE MD Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A. 238 6500 RIGGS ROAD 20783 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ऒ Yes 2 □ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: Specify: 5 3 ☑ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Hygiene. CUSTODIAN GOVT. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental H ant. If Item 27 is marked off lury or other traumatic aven Be TOMMIE LEE EDMONDS ANNA JONES 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES EDMONDS 1391 MORRIS RD.SE# 401 WASH.,DC. 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Durial 2 Crametion 3 Ramoval from Stata 4 Donation 5 Other (Specify) Department of Important: If any injury or VETERANS CEMETERY 1/5/00 CHELTENHAM, MARYLAND 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES 21. Signatura of Fynaral Saryice Licensee M1085 5538 Marlboro Pike, Forestville, MD. Though 20747 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset and Death **Physician** Immedieta Causa (Final disaasa or condition rasulting in daath) /Medical CARDIOVABULAR DISEASE **Examiner** The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting In death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Unknown Stage vaguer sementin - Vepetitione State Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? bral wardion thritiple dewhites ulcars

25. Wes casa referred to medical examinar? 2 0 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ EFVOutpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To this 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 8 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mennar stated. edicai 29a, Certifian (Check only one) within 2. To the F ş 29d. Data signed (Month, Day, Year) 29b. Signature and the pl certifian 29c. License number DECEMBER 26 1999 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) Queensbury Rd Hyathswille MD 20781 AUL A DE ORE

31. Data filed (Month, Day, Year) mD 4203 32. Registrar's Signatura

**DHMH 16 Ray 6/95** 

State

Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30, 1999 Approx 8AM December /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Westminster, MD Carroll Look About Manor Nursing Home If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Carroll Cty., MD 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex **Funeral** Min. 1□M 2⊠F Months Days Hours Yrs. June 4. 97 Director 176-05-3456 Usual Residence of Decedent deeth with the Maryland 10d. Insida City Limits or 28a-f ahow 10c. City. Town or Location 10a. State 10b. County 1XYes 2 No Hanover, PA 17331 Director York Pennsyl. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours effer deeth within Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 3 any injury or other traumstic event, the Medical Example must be nonce. USA 414 W. Walnut St., Hanover PA 17331 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 Never Married 2 Married 1 Yes 2 WNo Specify: specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) Administrative Receptionist Hospital 12 18. Mother's Nama (First, Middla, Maidan Sumame) 17. Father's Nama (First, Middle, Last) Be Mary Corbin John Hoffman 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1806 Bollinger Rd., Westminster, MD 21157 Earl Palmer/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 1/3/2000 | Hanover, PA 17331 4 Donetion 5 Other (Specify) Mount Olivet Cemetery 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee Kenworthy Funeral Home, Inc. (C0354 269 Frederick St., Hanover, PA 17331 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart to only one cause on each line. Approximete Intervel Between inset end Death **Physician** KESPIRATORY PAILURE Immediate Cause (Final disease or condition resulting In daath) /Medical Examiner Physician/Medical Examiner ettending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediata ceusa. Entar Underlying Cause (Disease or injury that initiated evants Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) resulting in death) Last 98 ed by the e 23b. Dfd tobacco use contribute to the cause of death? Part II. Other efanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown p 24b. Were autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of ceuse of death? hes 9 2 s page director, page 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes cese referred to medicel 26. Placa of Death (Check only one) 1 Yes 20 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Dea 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Accidant 5 Pending invastigation 1 Yes 2 No deeth. Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, deta end place, end due to the cause(s) end manner stated. 29a, Certifier edical (Chack only onei within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of or 30. Name and address of pelson wi npleted ceuse of death (Item 23a) (Typa, Print)

Airport Dr., Westminster, MD 21157

32. Registrat's Signature

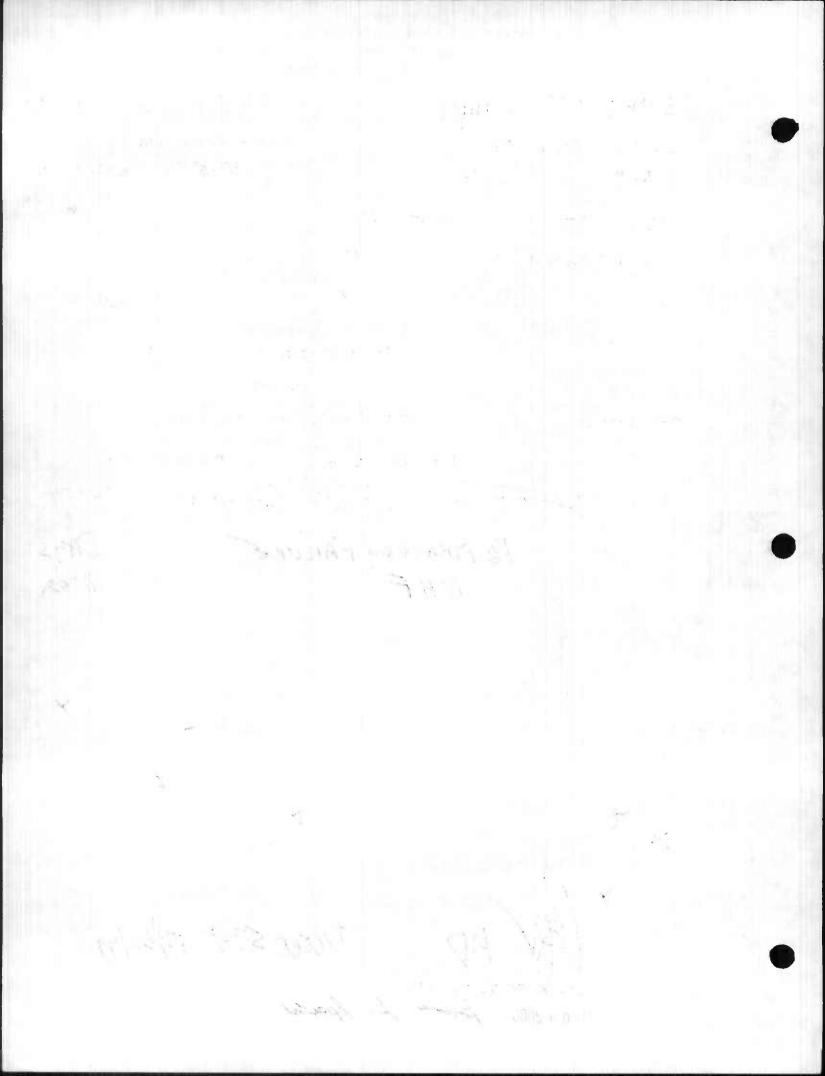
State

Registrar

Susan M. Bollinger

31. Date filed (Month, Day, Year)

JAN 0 4 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O

					Certific	cate of	Death	1000	Reg. No.	461	04	
Physician /Medica	_	1. Decedent's Name (First, Middle, Las STANLEY T.	" FITZGERA	LD				2. Date of D Month DECEW	Day	999 14	ne of Death	
Examine		4a Facility Nama (If not institution, give					4b. City, Town, or					
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Funeral Director		379-70-9200	X 2 F 7. Ag	e (In yrs. last b	Yrs.	ndar 1 Year ths Days		(Month, D	23,1960	9. Birthplace (S Country) Washingtor	tate or Foreign, D.C.	
and w	1	Usual Residence of Decedent  10a, State  10b. County		10c. City, Tov	vn or Location					10d. Insi	ide City Limits	
Mary	0	Maryland Montgome	rv	Rock	ville					1 08	Yas 2 No	
r 28a	2	10e. Street end Number	-1	ROCH		. Zip Code			10g. Citizen of What Country?			
h with	<u>=</u>	14209 Clayton Str	eet				20853		U.S	5.A.		
is yiellid Z IZ I 3-00ZQ should be filed within 72 hours after death with the Manyland of Mental Hygiene. marked other than "natural", or items 23s or 28s-f show imatic event, the Medical Exemples must be notified at TO Be Commissed by Finneral Director	anna ka	11. Marital Status  12. Was Decedent Event Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:			if Yes, specify Cuban, Mexican, Puarto				o- 14. Rac Biad Specify	e - Americen Indi kk, White, atc.		
72 hc	Sec.	15. Decedent's Ed (Specify only highest grad	ucation le completed)	168	Decedent's	Usual Occu	pation during most of wo d)	rkina	16b. Kind of Bu	usiness/Industry		
within 900.	d	Eiementary/Secondary (0-12)	Coilege (1-4or 5	5+)								
be filed withintal Hygiene. d other than event, pre.	3	AT FOR THE METERS AND A STATE A STATE AND ADDRESS AND	6yrs.		Qua	lity.	Assurance	me (First, Middle	Private			
yiding	9	17. Father's Name (First, Middle, Last)					16/					
should I ind Meni ind Meni ind Meni ind Meni ind Meni ind Meni	2	Walter Fitzgeral  19a. informant's Name/Ralationship (7)	trace (Strac	Lois Jones  Straet and Number or Rural Route Number, City or Town, State, Zip Code)								
2 9 9 9		Darlene Clyburn/W					n Street				0853	
ges 1 and 2 should tof Health and Mer if item 27 is marke or other traumatic	-	20a. Method of Disposition						Date		City or Town, Sta		
poemit. Pages 1 and Department of Health Important: If item 27 any injury or other thence.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			b. Place of Disposition (Name of cemetery, cramatory or other place) Phesapeake Crematory			12/31 1999	Dollar	110 Wo		
pemit. Pag Department Important: It any injury o	+	21. Signature of Funeral Service Licen		ematory 1999 Beltsville, Marylan Address of Facility CNKINS FUNERAL HOME								
permit. Departminentering importa		> Steak			7474	Land	over Road	d, Lando	over, Mar	ryland 2	0785	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	licetions that ceused ne causa on each li	the death. Do	not enter the	mode of dy	lng, such as cerdia	c or respiratory	arrest,	interv	ximate al Between and Death	
ificate be executed g physician and as the bunial-transit as the bunial-transit and fedical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CONGE b. PULM	Due to (or as a	Consequence	od): BZER od):	ISION					
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death death od for	SICIO	Part II. Other significant conditions of	ven in Pert i.	23b. Dlo	i tobacco use co	ntribute to the co	use of deat!					
requires that the death certification is signed by the attending hould be detached for use	y ruy	2511			10	□Yee 2□ No 3□ Probably 4 Unk						
3 2 2 2					nerformed?			opsy findings prior to on of ceuse				
The I	5							1 🗆	Yes 2 No	1 ☐ Yes	2 No	
vician: The lavicelan: The lavicelan: The lavicelans rector, page 2		25. Was cese referred to medical axaminer?						Plece of Death (Check only one)				
Physician: this certific ral director.	0	1 Yes 2□ No	Hospital: 1 inpatie		outpatient 3	J DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
oding Pluth. : After the funeral	TIOU:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of inju (Month, Da	ry y Year) 28b.	Time of fnjury M		c. Injury at Work?  1  Yes 2 No					
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	Serillic	3 ☐ Suicida 4 ☐ Homlolde  6 ☐ Could not be determined  28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital within 24 hours to the Funeral completely filled			elcian: To the best of the basis of and munner size								usa(s)	
To th Within	M	29b. Signature and title of certifier.	Charles Sta	DA	1	29c. Licen	sa number		29d. Data signe	Month, Day, Y	999 1999	
(25)		30. Name and address of person who of MARIO F. GOLY	ompleted cruse of d	eeth (Item 23e	(Type, Print) 3001 H	OSPITA	L PRIVE	CHEU	FLY, M	V-YLOND	20785	
State Registrar		31. Dete filed (Month, Day, Year)  JAN 0 3 2000	32. Registr	ar's Signature	do		,					
DI IN II 40 D CDF			1	~	· july							

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State of Maryland / Department of Health and Mental Hygiene 9 9 42705

			Ce	ertificate of	Death		Reg. No.		100		
	1. Decedent's Name (First, Middle, La	nst)				2. Date of		V	3. Tima of Death		
Physician	Thelma M.	Francis				Month	ember 30,	Year 1999	3:20 p.m		
/Medical Examiner	4a Facility Name (If not institution, gir	ve street and number)			4b. City, Tow	n, or Location of I		, , , , , , , , , , , , , , , , , , , ,			
<b>D</b> AGITITION	4800 Fox Street				Colleg	ge Park	Princ	e Geo	orge's		
Funeral Director		Sex 7. Age (In y	rs. last birthday Yrs.	Months Days	If Under 2	4 Hrs. 8. Data o	t Birth h. Day, Year) 9, 1924		Nace (State or Foreign		
	Usual Residence of Decedent					Journe	J, 1524	1226	21120		
Name of the last	10s. State 10b. County	1	0d. Inside City Limits								
To To	Maryland Prince	George's Hy	yattsvi.	lle					1 X Yes 2 No		
or 28e-f e	10e. Street and Number	What Coun	ntry?								
Sa Di	7706 Frederick Ro	ad		U.S.A.							
riber death with the Meryland of them 23a or 23a-1 ehow there must be notified at Them. Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U,S. 13.	Was Decedent of	Hispanic Origi		e - Americ				
5 6 -		Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cut  1 ☐ Yes 2 ☒ No		Puerto Hican, etc	Rican, etc.)  Bleck, White, etc.  Specify: White				
"natural",	15. Decedent's E		16a. Deci	edent's Usuel Occu	pation		16b. Kind of Bu	usiness/Inc	dustry		
	(Specify only highest gr		(Give	e kind of work done DO NOT use retire	during most ( ed)	of working					
omple	Elementary/Secondary (0-12)	College (1-4or 5+)	Secr	cretary			Day Ca		re		
other vent.	17. Father's Nama (First, Middle, Last	")			18. Mother	s Nama (First, Mi	iddle, Maiden Sumam	10)			
2000	Francis A. Morris	3				e Mahone	У				
la mari	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Addrass (Stree	t and Number	or Rural Route N	umber, City or Town,	Stata, Zin	Code)		
et la la la la la la la la la la la la la	Theresa F. Tucker						each, MD 2				
H E H	20a. Method of Disposition		b. Place of Disp	position (Nama of		Date	20c. Location -				
A Miles	1 Burial 2 Cremetion 3 C			ematory or other place tion Ceme		01/03/0	0 Clinton				
nding of the state	4 Donation 5 Other (Special Signature of Funeral Service Lice							, Mal	y Land		
Department of Heelth e Important: If Itam 27 is eny Injury or other tra ence.	PC Qaudo	tte 2. 2	11	Gasch's 1 4739 Balt			P.A. Hyattsvil	le, 1	MD 20781		
	23a. Part 1. Enter the disease, or con	pplications that caused the d	eath. Do not er	nter the mode of dy	ing, such es c	ardiac or respirate	ory errest,	1	Approximela Intervel Between		
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line.										
Medical	Immediate Cause (Final disease or condition	1 -	Months								
xaminer	resulting in death)	1	Months								
ě	Due to (or as a consequence of):  Metastatic Malignant Melanoma							12			
in end fal-transit Examiner	Sequentially list conditions	b. Due to									
Car X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
as the burlal-transit	that initiated events	c									
Po Ph	resulting in death) Last										
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igned by the ettendided detection of the ettendided for use by Physician/I	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause of	iven in Pert I	23h.	Did tobacco use co	otribute to	the cause of death		
h ch	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						1 Yes 2 No 3 Probably				
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een signe hould be o						24a.	Was an autopsy	24b. W	ara autopsy findings		
page 2 should to Completed							performed?	co	ailable prior to impletion of cause		
P 2 2								100	death?		
Com							1 ☐ Yes 2 ☒ No	10	JYes 2□ No		
certificate rector, pag Be Co	25. Was case referred to medical examiner?	14				of Death (Check o	only one)				
물로 나	1 ☐ Yes 2 ☒ No		2 ☐ ER/Outpatie	ent 3LI DUA		-	Residence 6 XOth		wSister's H		
rs after death.  al Director: After t ed in by the funer: Certification:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Data of Injury (Month, Day Year	28b. Tima Injury	Wo			ribe how injury occur	red			
Set Park	2 Accident investigation			M 10	]Yes 2□N						
the by	3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Ni City or Town, State)										
200											
within 24 hours after da yo the Funeral Direct completaly filled in by th Medical Certific	29a. Certifier (Check only 2 Medical Example)	hysician: To the best of my I miner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at tha t nvestigation, in my	ima, data and opinion, death	place, and due to occurred at the l	the cause(s) and ma ime, date end place,	e cause(s) and manner as stated. e, date end place, and dua to the cause(s)			
Me the	29b. Signature and title of certifier	o 1		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)		
1	1 Mardin	Oquia We	etzu	D2374	43		Decembe	r 31	1999		
201			0								
de	30. Name and address of person who					1100-			00770		
	Martin David Wel			way Cente	er Driv	re #205,	Greenbelt	, MD	20770		
State	31. Date filed (Month, Day, Year)	32. Registrar's Si		South	,						
Registrar	JAN 0 4 2000	merca	G.	soouls							

Jan 0 = 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend # 20b.& 20c. Per Fam.PGC 1-10-2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician AMANDA C. GREEN December 29, 1999 2:55PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Clinton Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 579-24-3458 1 M 2 XF 81 Yrs. Director 1918 Aug. 15, Wash., **Usual Residence of Decedent** the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "natural", or items 23s or 28s-f show the Wadical Examiner must be notified at 1 No 2 No District of Columbia Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 United States 2700 Jasper St., S.E. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. e filed within 72 hours efter dail Hyglene.
other then "natural", or frem 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: Black P 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked off jury or other treumatic even 8 Clara Riser Arthur Bonds 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) 4163 Southern Ave., #201, Capitol Heights, MD Stephanie Green - Daughter 20h Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Harmony Memorial Park 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Hyattsville, Md. parmit. Pege Department of Important: If eny Injury or pace. 1/7/2000 4 Donation 5 ☐ Other (Specify) ure of Funeral Service Licens 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Washington, D.C. 20019 23a. Parti. finter the disease, or complications that caused shock, or heart failure. List only one cause on each lie ed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervet Between Onset and Death **Physician** Immediate Cause (Finel /Medical disease or condition resulting in death) Pulmonary Embolism Examiner Due to (or as a consequence of): Examiner Myocardial Infarction The lew requires that the death certificate be executed physician end the buriel-traneit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. CHF Physician/Medical Due to (or as a consequence of): 080 Seizure Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Quadriplegia be det Records, by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed Bronchial Asthma completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien; 25. Was case referred to medical examiner? 8 26. Piace of Desth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inputient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. trijury et Work? 5 Pending n 24 hours effer death.

Ne Funerel Director: Africoletely filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0024208 December 31, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2000

Abulhasan U. Ansari, M.D.

32. Registrar's Signature

3. Spach

8926 Woodyard Rd., Suite 101; Clinton, MD

20736

JAN 0 4 2000

#### Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** December 28. Donald. Gray 3:20 P.M. /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 4501 Bishop Carroll Drive Upper Marlboro Prince George's | Upper | -----|
If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Pey, Dec. 6, 5. Sociei Security Number 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) **Funeral** 213-44-4653 Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nothered. 1 Yas 2 No Director Maryland Prince George's Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4501 Bishop Carroll Drive 20772 USA Funeral 12. Wes Decedent Ever in U,S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1968 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 Never Merried 2 Merried Specify: Black Saltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Russell Gray Rebecca Bowie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Bishop Carroll Dr. Upper Marlboro, MD 20772 Veronica Gray/Wife 20b. Plece of Disposition (Neme of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans' Cem. 1/4/00 Cheltenham, MD 21. Signeture of Funerei Service Licensee 22. Neme end Address of Fecility Sewell Funeral Home a. Sevell 1451 Dares Beach Rd. Prince Frederick, MD 20678 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a consequence of) physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initioted events resulting in deeth) Last Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Decubitus VIcer 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? has 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident M NIA 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner es stated.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) Silver HURD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 5+1 Emerson 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State

Registrar

**JAN 03** 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Gross Deborah Ann 28 /Medical DECEMBER. 1999 3:23 AM 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Pay, Year) Apr. 14, 1950 **Funeral** 1□ M 2XF Hours 214-58-1375 Yrs Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Heatth and Menial Hygiene. In: If item 27 is marked other than "natural", or items 23s or 28s-f show iry or other treumstic event, the Medical Examiner must be not an examiner must be not that an examiner must be not that an examiner must be not the most or other treumstic event, the Medical Examiner must be not that an examiner must be not the most or other treumstic event, the Medical Examiner must be not that an examiner must be not the most or other treumstic event, the Medical Examiner must be not the most of the most or other treumstic events. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland St. Mary's Dameron 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20628 USA 1441 Holland Manor Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 🗓 No Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oyster Shucker Seafood 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Coreatha Broome William Alexander 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 174 Ridge, MD 20680 Melvin Gross/Husband 20b. Pleca of Disposition (Name of cemetery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Department of Important: If eny Injury or once. Ernestine Jones Cemetery1/4/00 Chesapeake Beach, MD 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical CANCER OF The Brownt Examiner Examiner buriel-transit Hospital or Attending Physicien: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): DEBORAH GROSS Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): been signed by the a should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 s 1 ☐ Yes 20 No cartificate funeral director. Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) examiner?
1 Yes 2 No
27. Manner of Death Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 3DOA Certification: To Aftar this 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No Investigation tha 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical ş 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 17285 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. BOYD II M.D. 25365 POINT LOOKOUT ROAD LEONARDTOWN, MD. 20650

State Registrar 31. Date filed (Month, Dey, Year)

JAN 0 3 2000

32. Registrer's Signeture

G. Sparks

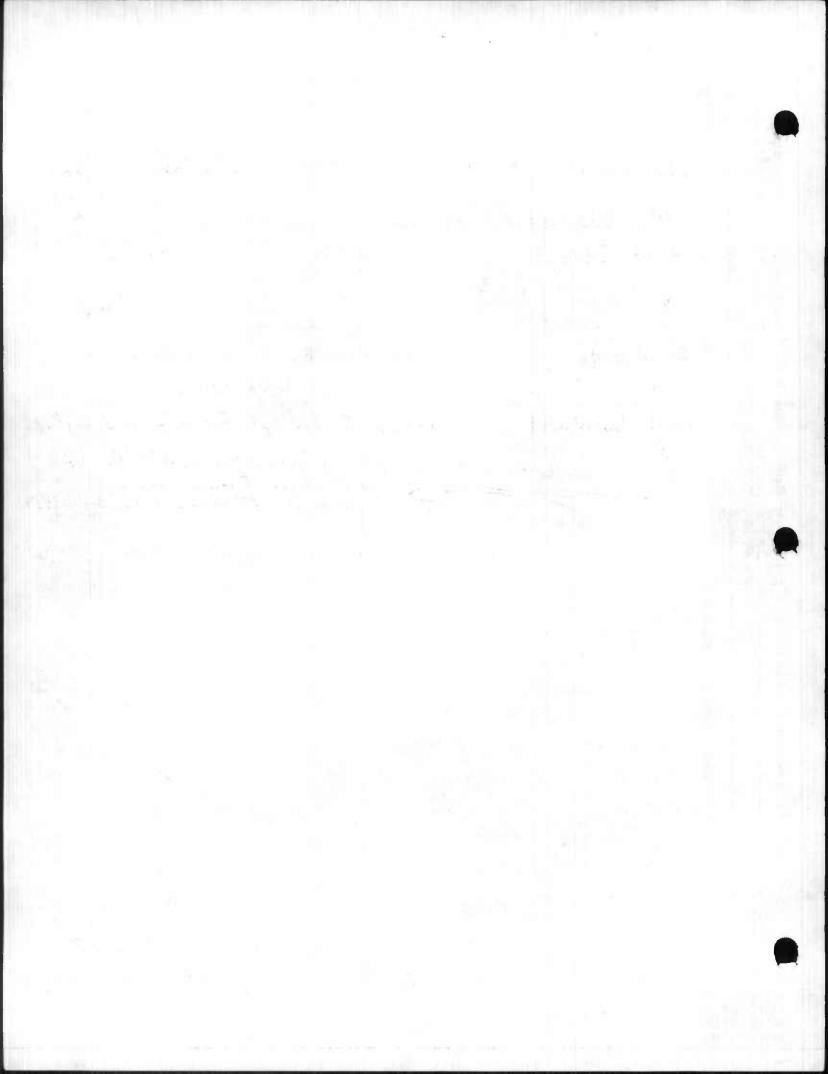
#### Piease Type or Print in Biack Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** Louise Harmon December 22, 1999 8:45 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis FlderCare Salisbury, MD Vicomico If Under 1 Year 8. Date of Birth (Month, Day, Year) 8-13-0 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 200 F Days Hours Months 222-05-4737 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location -how 10d. Inside City Limits Docomoka 1 Yes 2 No Director Worcester 10e. Street and Number 10f. Zin Code 10c. Citizen of What Country? 21851 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) "netural", or items 14. Race -Race - American Indien, Bieck, White, etc. 11 Marital Status filed within 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Marviand 21215-0020 1 ☐ Yes 2 No Specify Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department or Health and Mentel Hyglen, Important: if item 27 ie marked other than eny Injury or other traumatic event, the bacs. Scand grade

17. Father's Neme (First, Middle, Last) -WOFKET 18. Mother's Neme (First, Middle, Maiden Sumame) 8 UNKNOWN Brown Jeorge 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pocomoke Nea West cot 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadows 21851 md. 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Remove Irom State Church Como. 4 ☐ Donetion 5 ☐ Other (Specify) -29-99 Wattruille 22. Neme and Address of Fecility 21. Signeture of Funeral Service Licenses Smith ENNIE PoconoKa 331 10, Bux md,21851 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Myocandest Intersection /Medical Immediate Cause (Finel ANTERNO disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner physician end the burial-tranait Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown Torner Intection Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Dinlegles PVO SIP sextens, on 2 No 1 Yes 1 Yes 2 No Division of Vitai Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours efter death.

The Funeral Director: After tipletely filled in by the funeral After 5 Pending investigation 1 Netural 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) MO 30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print) Clerke SoleSMD ZIBUY MATKINS 1104 31. Dete filed (Month, Day, Year) 32. Begistrar's Signature State JAN 07 Registrar



#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day Day 29 **Physician** 2:34PM Ronald Maurice Henry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth (Month, Day, Yeer) May 14, 1949 if Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 6. Sex 12M 2DF 7. Aga (In yrs. last birthdey) 9. Birthplaca (State or Foreign **Funeral** Min. Months Days Hours 50 Wash., D.C. 578-66-7631 Director Usual Residence of Deceden the Marylenc 10d. Inside City Limits 10c. City, Town or Location 10a. Stata 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified as 1 Yes 2 □ No Directo Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 United States 12306 Snowden Woods Rd. Funerai 12. Was Dacedant Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas; 14. Race - Amarican Indian Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. African 1 Naver Married 2 X Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) (Give kind of work done during most of working life. DO NOT use retired) Cottege (1-4or 5+) Elementary/Secondary (0-12) 5+ Physician - Cardiologist Self Employed 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Gloria Ann Hill Joseph L. Henry, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara W. Henry, M.D./Spouse 12306 Snowden Woods Rd., Laurel, MD 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2000 Harmony Memorial Park Landover, MD Stewart Funeral Home 22. Nama and Address of Facility 21. Signiture of Funeral Servica Licensee 4001 Benning Rd., N.E. Wash., D.C. wary 23a. P. L. Entar tha disaasa, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ship or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) **Examiner** Examiner physician end s the burief-transit the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 use signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 2 X No 3 Probably 4 Unknown 1 Yes Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 785 1 Yes 2 No certificate Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nepatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 Yes 2 No 2 Accident investigation or Attendation of the deep 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, State) 3 4 Homicide Hospital or / 24 hours after
 Funeral Directory filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 30 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catarenis, 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Dey, Year, 32. Registrar's Signature JAN 0 3 2000 Registrar

A BOSS & C MAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death Month **Physician** 0929 DECEMBER 29 999 cation of Death | 4c. County of Death Rena Louise Hamilton /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner CAPITOL HEIGHTS PUNCE GERGES TORQUE STREET 4215 8. Data of Birth (Month, Dey, Year) Oct. 15, 1 If Undar 24 Hrs. If Under 1 Year 5. Social Securify Number Birthpleca (State or Foraign
Country) 7. Aga (In yrs. last birthday) 1 M 2 XF Months Deys Hours Min Yrs. 577-74-1325 Mary land Usuel Residance of Decedant 10d. Inside City Limits 10e Stete 10b. County 10c. City, Town or Location 1 AYes 2 No Capitol Heights Maryland Prince George's Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4215 Torque St. 20743 United States Funeral 13. Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva 14. Race - American Indian 11 Marital Stetus Black. Whita, atc. 1 Navar Marriad 2 Married 1 Yes 2 No Specify: **Black** Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Private Service Worker 12th 18 Mother's Nama (First Middle Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Sarah Colbert Robert Harper 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Neme/Ralationship (Typa, Print) 3200 Oak St., Upper Marlboro, MD 20772 Alice E. Addison - Daughter 20b. Place of Disposition (Nema of cematary, cramatory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2000 Lincoln Memorial Cem. Suitland, MD 22. Nama end Address of Fecility 21. Signature of Funeral Sarvice Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 the diseasa, or complications that caused the de in Do not antar tha mode of dying, such es cardiac or raspiratory errast, Approximata Interval Between Onsat and Death Immedieta Causa (Final . APTERIOSCUERDITC CARPIOVASCULAR DISEASE disaasa or condition resulting in death) Dua to (or as a consaquanca of): Examiner Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Ceuse (Disaese or Injury that initiated avants resulting in death) Lasf Dua to (or es a consequence of): Physician/Medical Due to (or as a consaquance of): Part II. Other significant conditions contributing to death but not rasulting in tha underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings availabla prior to complation of cause of daath? 24e. Was en autopsy Completed 2 No 1 Yas 1 □ Vas 2 □ No Be 25. Was cesa rafarrad to madicel 26. Place of Death (Check only ona) axaminarr 1 Yas 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be 3 Suicida 281. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, straet, factory, offica building, etc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar sestated.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29a, Certifier Medical

29c. License number

29d. Data signed (Month, Dey, Year)

PRIVE, CHEVERLY, MARYLAND 20785

Division of Vital Records, P.O. Box 68760,

law requires that the death certificate be axecuted 980 signed by the at id be detached for been si certificate has birector, page 2 s The Hospital or Attending Physician: this After daath. after daatl Director: To the Hospital or Atter within 24 hours after day To the Funeral Director completely filled in by the

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Manyland sent of Health and Mental Hygiene.

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**Physician** /Medical

**Examiner** 

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Baltimore, Maryland 21215-0020

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State Registrar 29b. Signatur

GOLLE MARIO F. 31. Data filed (Month, Dey, Year)

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tuse of death (from 23a) (Type, Print)

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedant's Neme (First, Middle, Last) Month Harrison **Physician** May 1999 9 30 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Regional Hospital Laure Laure If Undar 1 Yaar | If Undar 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex. 4☑ M 2□ F **Funeral** Days Min 213-16-2612 82 Months Hours 5/14/17 Director Muirkirk, Md. Usuel Residence of Decedent with the Marylend 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Examinal must be notified at 1 Yes 2 □ No Md. P.G. Beltsville Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7808 Muirkirk Road 20705 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 ⊠ Yes 2 □ No If Yas, Give 1,43 - 1,45 Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0020 by 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'n any Injury or other traumatic event, tre Med Ance. Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Aid U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Edward Gross Ethel Harrison 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lajoele A. Smalls/Daughter 14933 Belle Ami Dr., Laurel, Md. 20707 20b. Plece of Disposition (Name of cemetery, crematory or other place)
Maryland Nat'l.Mem.Park 1/4/00 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Laurel, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
H.S. Washington & Sons Co., Inc. 21. Signetura of Funeral Sarvice Licensae ann rate 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disaasa or condition resulting in death) /Medical day Examiner Due to (or as e consequence of) Physician/Medical Examiner englishe ettending physician and for use as the bunal-trensit The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events and Due to (or as a consequence of): Bulesian Dua to (or as a consaquence of) resulting in deeth) Lest ed by the e Pert II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 Yes 2 No 3 Probably 4 Unknown recenter þ 24b. Were eutopsy findings aveilable prior to completion of ceusa of deeth? 24e. Wes en eutopsy performad? Completed peen alpression has 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Hospital or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Impatiant 10 2 ER/Outpetient 3 DOA After this 28e. Dete of Injury (Month, Day Year) 27. Menne of Deeth 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier 29c. License number 29d, Dete signed (Month, Day, Year) 29b. Signature-and-gitte of-certifie D13659 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3450 Fort Mde Rd. Md. 20794 Va

32 Registrer's Signeture

**DHMH 16 Rev 6/95** 

State Registra

31. Date filed (Month

184 9 3 2010 James 13 June 19

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42713

	Decedent's Name (First, Middle, Last	st)		ertificate		ouin-	2. Date of De	Reg. No.		3. Time of Death	
hysician	Marie Hamlin	54)					Month	Dey	Year	10:30 AM	
/Medical	4a Facility Name (If not institution, give	a ctraat and number)			4b	. City, Town, or L	Decem!		1999	10,30 1/11)	
xaminer	NORTH ARUND		TTAL		6	IFN 1	BURNI	EANN		DUNINEI	
neral	5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthda	y) If Under 1 Months	Year	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Di 01-26		/ /	place (State or Foreign	
ector		□M 2√F 87	Yrs.	MOTHETS	Days	TTOURS WINT.	01-26	-12"	Virg	place (State or Foreign http:) inia	
	Usual Residence of Decedent  10a. Stata 10b. County	10c.	City, Town or	Location					1	0d. Inside City Limits	
notified at	D. C.		Washin							1≹ Yes 2 No	
be notified	10e. Street and Number		Wasiiiii	10f. Zip C	Code			10g. Citizen of	What Coun	ntry?	
	1400 Fairmont S	t., N. W.			20	0009		U. S.	Α.		
dosc must.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13	3. Was Decede	ent of His	panic Origin? (Sp. Mexican, Puerto	pecify Yes or No	- 14. Rac	e - Americ		
b	1 Never Married 2 Married 3 MVidowed 4 Divorced	1 Yas 21 No If Yes, Give Year or Dates:		1 ☐ Yes 27		Specify:	ricall, etc.)		ck, White, y: Bla		
disal disal	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	edent's Usual	Occupati done du	ion ring most of work	kina	16b. Kind of B	usiness/Inc	dustry	
event, the Medical Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)						0.10	T 1	1	
00	7th 17. Father's Name (First, Middle, Last)		Hou	seKeepi		8. Mother's Nam	a (First Middle	Self-	<u> </u>	yed	
Be o	Unknown						Bell	, .na.our ourret			
To	19a. Informent's Name/Reletionship (	Type, Print)	19b. Me	iling Address /	(Street an	nd Number or Ru		er, City or Town	State, Zio	Code)	
5	Ann V. Haynes	Daughter		The state of the state of		ng Ave.,					
	20a. Method of Disposition		o. Place of Dis	position (Name	e of her place		Date	20c. Location	City or To	own, Stata	
ווא פר	1  Surial 2  Cremation 3  □ 4  Donation 5  Other (Specify		m State Quantico National					Triangl	e, Va	•	
8	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  13. If I DACON FINERAL HOME TWO										
# 8	W. H. BACON FUNERAL HOME, INC. 3447 14th St., N.W. Washington, D. C. 20010										
	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not e						1	Approximate Interval Between	
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odical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or es a cons	edneuce ot):					1		
edical	Cause (Disease or injury	cDue to	o (or as a cons	equence of):							
	resulting in death) Last										
Completed by Physician/M		d							1		
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n: To Be Com	1 Yes 2√2 No 27. Manner of Death	28a. Date of trijury	ER/Outpati		c. Injury a	4   Nursing H		how injury occur		y)	
t lor	Natural 5 ☐ Pending investigation	(Month, Day Year		м		es 2 □ No					
He	3 ☐ Suicide 6 ☐ Could not be determined	288. Place of Injury - A	t home, ferm,	street, fectory,	office		28f. Location	Street and Numi	ber or Rura	al Route Number,	
C C	+ LI HOHIICIDE	building, etc. (Spe	эспу)				City or To	wn, State)			
Medical Certification:	29a. Certifier (Check only one)	ysician: To the best of my k iner: On the basis of exam and menner steted.	nowledge, dei ination and/or	ath occurred at investigation, in	t the time in my opir	, date and place, nion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	tated. o the cause(s)	
completely filled in by the funeral Medical Certification:	29b. Signature and title of certifier			29c.	License i	number		29d. Data signe	ed (Month,	Day, Year)	
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1	30. Name and add a person who o	completed cause of death (I	tem 23a) (Typ	e, Print)		^		MD.	. 1		
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		- Daughter	-			Street,					
19a. Informant's Nam	e/Ralationship (7	ype, Print)	19b.	Mailing Ad	dress (Stre	eet end Number or R	ural Routa Numbe	r, City or Town, S	teta, Zip Cod	a)	
Benjamin	Franklin	n Aylor				Laura B	elle Har	ris			
17. Fether's Nama (Fi	irst, Middle, Last)		110			18. Mothar's Na	ma (First, Middle,				
Elementery/Second	lary (0-12)	Collaga (1-4or 5-		memak		1100)		Own Hom	e		
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3 🖾 Widowed 4		Yaar or Datas:						Specify:	***********		
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Maryland   10e. Street and Numb	Prince G	eorge's	Hyatts		of. Zip Code	9		Iog. Citizen of Wh		zję/140	
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I. Decedent's Name (	First Middle Les										
	/First Middle I as			Certifi	cate o	f Death		Reg. No.	- 1		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within EA hours after deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burle-transit

State Registrar

Hongrak Sch 31. Dete filed (Month, Day, Year) JAN 0 4 2000

Director

Funeral

by

Completed

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Examiner

Physician/Medical

Be Completed by

Medical Certification: To

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medicai Examiner

Baltlmore, Maryland 21215-0020

mnD 035848 12/30/99

I cause of death (Item 23e) (Type, Print)

- 5 ~ 1438 Defense they Gambrills, mnO 21059

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Security

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## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:30 p.m. GREGORY GRIGGS HAWK 30 - 99/Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 12 M 2□ F Director 220-42-4375 53 6-16-46 Washington D.C. Usual Residence of Deceden 10a. State 10d. Inside City Limits 10b. Count 10c. City. Town or Location 1√ Yes 2 No Directo 28a-f Maryland Prince Georges Clinton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 23a 3707 Blackwater Road 20735 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Black, White, etc. Amed Forces:
1 Ness 2 No -22-64
If Yes, Give 6-21-68 72 hours after 1 Never Married 2K Married 21215-0020 8 1 ☐ Yes 2 ☒ No Specify: Specify: Black Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Transportation Supervisor - Metro Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill mant of Health and Mental H lant: If hem 27 is marked oth lury or other traumatic even Maria Griggs James W. Hawk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roena V. Hawks / Wife 3707 Blackwater Road, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 1-06-00 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Funeral Service Lio 22. Name and Address of Facility Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748 our 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Non Hodykins Examiner Examiner The lew requires that the deeth certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate has 1 Yes 2 No 1 Yes 2 No of Vitai or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1□ Yes 20 No Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this s alter deem.

I Director: After the by the funare funarai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 TYes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral complately filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D46246 10 30. Name and address of yerson who completed cause of death (Item 23a) (Type, Print) WALDORF MD MEELU 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State JAN 0 5 2000 south Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ALFRED CARROLL HENDERSON, SR. **DECEMBER 31, 1999** 5:33 P.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMP SPRINGS PRINCE GEORGE'S MALCOLM GROW MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day 6. Sex 12 M 2 ☐ F 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country), 26,1942 Washington, D.C. Months Davs 131-32-9738 57 Yrs. November Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland | Prince George's 1 Yes 2 □ No Suitland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4413 Rena Road, #3 20746 U.S.A. Funerai 12. Was Decedent Ever in 15/60 Amped Forcas? 00/29/60 1 M Yes 2 No 11/26/42 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2K No Specify: Black. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessee Brice Alice Henderson 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Henderson/Wife 4413 Rena Road, #3, Suitland, Maryland 20746 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 01/10 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cametery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Cheltenham, Maryland 21. Signatura of Funaral Service Licenses 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME Percen Nancy 7474 Landover Road, Landover, Maryland 20785 W 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. Dist only one cause on each line. Approximate Interval Between Onsat and Death Immediate Causa (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION 1 DAY Due to (or as e consequence ot): SEVERE CORONARY ARTERY DISEASE 1 YEAR Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) DIABETES MELLITUS Due to (or as a consequence of): HYPERTENSION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TOBACCO ABUSE 24a. Was en eutopsy performed? 24b. Were autopsy tindings evailable prior to completion of causa of death? CARDIO PULMONARY ARREST 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1% Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. 29e, Certifier (Check only one) 29b. Signatura and titla of certitier 29c. License number 29d. Date signed (Month, Dey, Year)

CA A060847

JANUARY 1, 2000

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**Funeral** 

Director

raff, or items 23a or 28a-f show Examiner nast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with til Department of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2. eny injury or other traumatic event, the Medical Experiment must be appear.

Physician /Medical

Examiner

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signed by the at d be datached for

has page 2

certificate

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24 hours after death.

Hospital

funeral director,

the

filled in by

and

physician

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Division of Vital or Attending Physician: Physician/Medical Examiner

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Completed

Be

Certification: To

Medicai

Baltimore, Maryland 21215-0020

the Maryland

31. Date tiled (Month, Day, Year) State JAN 0 5 2000 Registrar

PEERACH P. PHERMSANGNGAM, CAPT, USAF, MC ANDREWS AFB, MD 20762-6600 32. Registrar's Signature

30. Name and eddress of person who completed cause ot death (Item 23a) (Type, Print) 89 MDG/1050 W PERIMETER RD

9005 C 7 V21

State of Maryland / Department of Health and Mental Hygiene ()

			O.E.	funcate of Death	Reg.
	1. Decedent's Name (First,	Middle, Last)			2. Date of Death
Physician /Medical	TELGIU	Keith Ha	all		Month 12
Examiner		stitution, give street and r	number)	4b. City, Town, or L	ocation of Death
	Fort Washi	ngton Med:	ical Center	Ft. Wash	ington
Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Data of Birth (Month, Day, Ye

**Director** 

Directo

Funeral

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Completed

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with the Maryland r than "naturel", or items 23s or 28s-1 show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a eny linjury or other traumatic event, the Medical Examine must once.

altimore, Maryland 21215-0020

**Physician** /Medical Examiner

death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

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Physician/Medicai

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Completed

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Certification:

Medical

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Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Lest

25. Was case referred to medicel axaminer?

5 Pending

1 Yes 2 No

27. Manner of Death

1 Naturai

3 ☐ Suicide

2 Accident

4 | Homicide

ettending physician and for use es the buriel-trans 9 6 signed t page 2 certificate hes director. uneral After s after death.

filled in by Hospital 24 hours completely To the To the To the F

Registrar

4c. County of Death Prince George's 9. Birthplace (State or Foreign 220-62-6120 45 09-07-54 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No MD Prince George's Ft. Washington 10e Street and Number 10g. Citizan of What Country? 3405 Stonesboro Road 20744 United States 12. Was Decedant Ever in U,S Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowad 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Metro 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Arthur Hall Marian Delores Makle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Stonesboro Rd., Ft. Washington, MD 20744 lace of Disposition (Name of Date 20c. Location - City or Town, Stata Jacqueline Hall / Wife 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 17 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

Resurrection Cemetery 1/8/00 Clinton, MD 21. Signature of Funerai Service Licensee 22. Name and Address of Facility Felton Funeral Services sell P.O. Box 1351, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Between Onsat and Death

Immediate Cause (Final a Myocardial Infarction disease or condition resulting in death)

Due to (or as a consequence of):

Nonobstructive hypertrophic cardiomyopathy Due to (or as a consequence of):

Due to (or as a consequenca of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Hyperthyroidism

Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28h Time of

6 Could not be determined

28c. Injury at Work? 1 Yes 2 No

28e. Placa of injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

1 X Yes 2 □ No

1 Yes 2 No

28d. Describe how injury occurred

24a. Wes an autopsy performed?

28. Piece of Death (Check only one)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth?

1 ☐ Yes 2 ☐ No

3. Time of Death 5:37 PM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c, License number 29d. Date signed (Month, Day, Year)

29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D52176

Karen McGibbon, MD, 5100 Auth Way, Suitland, MD 20746.
31. Data filad (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 62718 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0623 AM EUNBOUNE HOUMES 31 Octorbor /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TAKOWA DOLK MOSHINGON AOUGUTIST Hospita MONTED MENT If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 577-40-8549 Sept. 19, 1927 Washington, DC Director 72 Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d Inside City Limits must be notified at Washington 1 N Yes 2 No D.C. N/A Directo 10a Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23s 20012 U.S.A. 6428 North Capitol Street N.W. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Hygiene. Other then "n Elementary/Secondery (0-12) College (1-4or 5+) Dept. of Navy File Clerk 12th permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Harrison 2 Edward T. Holmes 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 6428 North Capitol St., N.W. Washington DC 20012 Deborah Lee - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1-10-00 Alexandria, Va. Metropolitan Crematory 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 4217 9th Street N.W. Washington DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heer failure. List only one cause on aech line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel APPENIOSCIONOTIC CAMONAMISCUM O'GOTO disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner ENO-SMOUT ROWN DISEME certificata be axecuted burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or es a consequence of) and physician s s the burial-HYPENTOUSION Box 68760. Physician/Medical Due to (or es a consequence of): 980 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably Winknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has 1 Yes 2 No certificate Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Daath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: al or Attending F s after death. Affer 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital

To the Hospital
within 24 hours a
To the Funeral Completely filled

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31. Dete filed (Month, Dey, Year) JAN 0 5 2000

d title of certifier

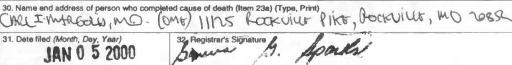
29a, Certifie.

29b. Signatu

(Check one)

32 Registrar's Signature

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

015236

29d. Date signed (Month, Day, Year)

Occan 800 31, 1999

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Yaar Physician 卫 Alvin A. Ha11 1248 Am 30 1999 December /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore SIMAI HUSDIAL ff Under 24 Hrs. 8. Date of Birth Month, Day Year) 1945 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9 Birthplace (State or Foreign **Funeral** Days Months Mary Tand 230-77-2898 Yrs. Director Usual Residence of Decedent the Meryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Itam 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumstic event, the Medical Examinar must be notified at 1 Yes 2 No Calvert Owings Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filled within 72 hours effer deeth with 1 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or frams 23a or 2 shiplury or other traumatic event, the Medical Exemples must be appare. 5840 John Chapel Road 20736 USA Funeral 12. Waa Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Plumber Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 80 Frank Hall Annie T., Holland. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Vernita Jones/Sister 514 Race St. Fairmont, West Virginia 26554 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Hope UM Church Cem. 1/5/00 Sunderland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd. Prince Frederick, MD 20678 Surll 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laiture. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) neumania Examiner Due to (or as a consequence of): Examine attending physicien and for use as the burlal-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? ed by the a Division of Vital Records, P.O. 3 Probably 4 DUnknown 1 Yas 2 No à 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? Completed peen : completion of cause of death? certificate hes 1 Yas 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this funarel 28a. Date of Injury (Month, Day Year) ve Hospital or Attending Pi in 24 hours after death. The Funeral Director: After t pletaly filled in by the funera Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 5 Pending investigation 1 DNatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, atreet, lactory, office building, etc. (Specify) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To the To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 1015TUL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weister SIMAI HUSDITAL Anonew 31. Date filed (Month, Day, Year) 32. Registra/s Signature State **JAN 03** 2000

**DHMH 16 Rev 6/95** 

Registrar

of the said

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** 29, 1999 EDWARD (NMN) JREIGE DECEMBER 10:14 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner National Institute of Health Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) Mo 1 houses 5. Social Security Number 8. Sex **Funeral** 1 → M 2 □ F Days Dec. 14, 1967 Australia Months Hours Min. 32 Yrs. 132-66-8981 **Director** Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10e State 10b Count 10c. City, Town or Location 10d. inside City Limits or 28a-f show Erie NO Yes 2 No New York Cheektowaga Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? \*natural", or items 23s or solical Examiner must be ā 83 West Cavalier 14227 U.S.A. Funer 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Hygiene. other than \*natura ent, the Medical Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Induatry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mentel Hygien Important: if item 27 is marked other th. any Injury or other treumatic event, the. 12th Unemployed N/A 18 Mother's Name (First Middle Meiden Surneme) 17. Father's Name (First, Middle, Last) Be Anthony Jreige Madeleine Shady 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cametery, cremetory or other piece)

83 West Cavalier, Cheektowaga, NY 14227
20c. Location - City or Town, State Anthony Jreige - Father 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-6-00 Holy Cross Cemetery Lackawanna, New York 22. Name and Address of Fecility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11/600 4217 9th Street N.W. Washington DC 20011 23a Prof. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel NONSPECIFIC INTERSTITIAL LUNG MONTHS disease or condition resulting in death) Examiner Examiner PNEUMONIA VENTILATOR ASSOCIATED week physicien end the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 98 esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No LIPODYSTROPHY 3 Probably 4 □ Unknown INSULIN RESISTANCE Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate hes t director, pega 2 s 1 Yes 1 ☐ Yes 20 No 2 No Attending Physician: funeral director. 25. Wes case referred to medical 26. Piece of Death (Check only one) exeminer? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yea 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No deeth. N/A. investigation efter deetl Director: 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homlcide ŏ 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number (MD) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1999 UMD 00052707 30. Neme and edocase of person who completed cause of death (Item 23a) (Type, Print)

State Registrar J.

MACCHIO

eleva

32. Registrar's Signature

M ) 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

Gregory

31. Date filed (Month, Day, Year)
JAN 0 4 2000

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State of Manyland / Department of Health and Mental Hydienes

				State of M	arylari				Death		Reg. No.	42	1721	
Physi	aian	1. Decedent's Nar	me (First, Middle, Last	)						2. Date of De Month	ath Day	Year	3. Time of Death	
/Med		Clifto	on Willia	m Johns	on					DECEN	118ER 31	1999	1:34 PM	
Exam		4a Facility Name	(If not institution, give	street and number)				4	lb. City, Town, or	Location of Deat	4c. County	of Death		
40		Doct	or's Hos	pital			Lanham				Prin	ce Ge	eorges	
Funera	1	5. Social Security			e (In yrs. i	last birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th Year)		ace (State or Foreign	
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у .		Usual Residence			1									
the said		10a. State	10b. County		10c. City	, Town or Loc	ation					10	d. Inside City Limits	
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E 20 E	- ire	10e. Street and N	umber				10f. Zip	Code			10g. Citizen of 1	What Countr	ry?	
6 2 1		3605 CI	lairton D	rive			1	2072	21		Unit	ted S	tates	
E 22 5		rried 2[X] Married	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ if Yes, Give Year or Dates:		If	/as Deced Yes, spec	cify Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		ck, White, e	tc.		
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	17. Father's Name	(First, Middle, Last)	2					18. Mother's Nar	ne (First, Middle		ne)			
	George	Johnson					Alice	Dashie	1.6					
2 should and Management	F		Name/Relationship (T)	me. Print)		19b. Mailing	Address	S (Street				State, Zio (	Code)	
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Pages nert of a		1 X Burial 2	Cremation 3 □F			emetery, crem								
Baltimore			5 ☐ Other (Specify)		Cr	ossro				1/7/00				
Ba and and and and and and and and and an		21. Signature of	uneral Service Licens	96	1	) 22.	Name ar	nd Addres	ss of Facility H	odges a	Edwa:	rds F	ъ.н.	
W. COTH		190	nue Z	duran	02	ノ  39	10	Silv	ver Hil	1 RD.	Suitla	nd, M	ID. 20746	
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Q & £ 8	hy		1 ) -			ulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death			
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Vision Attending or death. ector: After	atlo	2 Accident	investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	,-,,	М		Yes 2 □ No					
= 24 ¥ E	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of tnj building, et	ury - At ho c. (Specify	me, farm, stre	et, factor	y, office		28f. Location ( City or To	Street and Numi wn, State)	ber or Rural	Route Number,	
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To the Within To the	Σ	29b. Signature an	d title of certifier				290	c. Licens	e number		29d. Date signe	ed (Month, D	Day, Year)	
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(1)	)	30. Name and ado	lress of person who co	74	eath (Item	23a) (Type P	Print)	- 1			. 0	, , (		
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State of Maryland / Department of Health and Mental Hygiene 9 9	la	2	7	2	2
Cortificate of Dooth					

				Ce	inioato t	of Death		Reg. I	No.			
_	. Decedent's Nama (First, Midd	fle, Last)		_				ate of Death	Day Year			
sician edical	ELVIRE		JACKS	SON			1 -		24, 1	.999	9:30	
	a Facility Name (If not institution	and the same of the same					wn, or Location		4c. County			
	VA Maryland				T #31-14 W		ry Poin		Ceci			
5.	Social Security Number	6. Sex 1 ☐ M 2 🗷		yrs. last birthday)  Yrs.	If Under 1 Y	ear if Under	Min. 8. D	ata of Birth fonth, Day, Yes 21/10	ar) 1	WASHIN	GTON,	
U	578-24-5030		J.	9			//	21/10				
_	0a. State 10b. County			c. City, Town or Lo		T			100	d. Inside Cit		
tor	DC	N/A	1	WASHINGT	ON						1 Yes	
Funeral Director	0e. Street and Number				10f. Zip Cod	de		10g. (	Citizen of V	Vhat Countr	y?	
la l	429 QUACKENBO	S ST NW				20011			US	A		
aur 1	1. Marital Status	Arme	Decedent Ever d Forces?	in U,S. 13.	Was Decedent If Yes, specify (	of Hispanic On Cuban, Mexican	igin? (Specify )	res or No- , atc.)	14. Race Blac	e - America BLACK	n Indian, ic.	
by Fi	1 Never Married 2 Mai	If Yes	, Give	US ARMY	1 Yes 2				Specify			
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To B	ASHWORD D. HOL	DER				A	GNES A	DA DAVI	S			
1	9a. Informant's Name/Relation							ral Routa Number, City or Town, State, Zip Code)				
	LANCELOT A. HO	LDER (NE			ME AS 1		D,E,&F	E,&F				
20	0a. Mathod of Disposition  1√□ Burial 2 □ Cremation	3 □Ramoval fi	rom Stata	20b. Place of Disposition (Name of cemetery, crematory or other place)			Da	Date 20c. Location - City			m, State	
	4 Donation 5 □ Other (			Quantic								
2	1. Signature of Funeral Service	Licensee	C60273	10 2	2. Name and A	ddress of Facili	T MHOL	RHINE	s co.	, INC		
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2	23a. Part1. Enter the disease, of shock, of heart failura. Lis	t only ona causa	hat causad tha on each line.	daath. Do not en	tar the mode of	dying, such as	cardiac or ras	piratory arrest,		1	Approximate interval Bety Onsat and D	
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d	mmediata Causa (Final lisaasa or condition	, Chr	onic Ob	structiv	re Pulmo	onary D	isease	Exacerb	pation	1	Unkno	
201	Due to (or as a consequence of):											
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cal E	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events Sequence of):  Due to (or as a consequence of):											
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	resulting in death) Last  Due to (or as a consequence of):											
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Carroll County, wil State of Maryland / Department of Health and Mental Hygiene Amended Item 1, per Phy. Amended Items 12, 17, 19a, per F.D. 1/10/2000 Certificate of Death 1. Decedent's Neme (First, Middle, Last) JUSTIN ROBERTSON LAWSON, JR. 2. Date of Death 3. Time of Death December 29, 1999 **Physician** Justin Robertson Lawson 9:50pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 510 Piney Run Court Sykesville If Under 24 Hrs. 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 56 217-40-1214 Yrs. Director April 27, 1943 Maryland Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at MD Carroll Sykesville 1 Yes 2 No Director 284-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 510 Piney Run Court 21784 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1962= 11962= 11968 Yesr or Detection 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or Detection 1961 | 1968 Yesr or D 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Herra: 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 8 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Supervisor of Ad Operations Newspaper poemit. Pages 1 and 2 should be fits
Department of Health and Mental Hy,
Important: If Nam 27 Is marked other
any Injury or other the Maryland 17. Fether's Neme (First, Middle, Last) Justin Robertson Lawson, Sr. 18. Mother's Name (First, Middle, Maiden Sumame) Be Justin Robertson, Sr. Anna Marie Breivogel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary A. Lawson (Wife Mrs. Mary D Lawson (Wife) 20e. Method of Disposition 510 Piney Run Court, Sykesville, MD 21784 Baltimore, 20b. Place of Disposition (Neme of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/2000 Springfield Cemetery Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL (PO Box 195) Varda suan o Sykesville, MD 21784 (410)-795-1400 23e. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. **Physician** /Medical months Immediate Cause (Final oma disease or condition resulting in deeth) Examiner Examiner Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): and Box 68760 physician Physician/Medical the Due to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy nedormed? peed completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Division of Vitai funeral director, 25. Wes case referred to medicat 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Netural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 3 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. edicai 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Hille of certified 29c. License number December 31,1999 30. Name and address of person who compl of death (Item 3a) (Type, Print) N. Charles St. Balto, md 21204 6701 -A. Riley 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signature State JAN 0 5 2000 Registrar

ANDESON Journ to francis

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42724

					Cei	rtificate	e of i	Death			Reg. No.			
	1. Decedant's Nam	na (First, Middle	e, Last)							2. Date of De	eath Day	Year		ne of Death
Physician /Medical		EMII	LY LANDA									1999		30 AM
Examiner	The state of the s		n, give street and no VE ADVEN	mber) TIST HO	SPIT			ROC	KVI	LLE		County of De	OMER	
Funeral Director	5. Social Security N	1905	6. Sex 1 ☐ M <b>2</b> ☐ F	7. Age (In yrs. last	Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D JAN • 9	rth ay, Year) , 190	9. B	irthplece (St Country) W YO	ete or Foreigr RK
deeth with the Meryland ms 23a or 28a-f ehow Linual De notined at neral Director	10a. State MD •	10b. County	GOMERY	10c. City, T		cation OCKVI	LLE	3					de City Limits Yes 2 No	
th with the Meryla 23a or 28a-f eho unt be notified at al Director	10e. Street and Nu		DRIVE			10f. Zip					10g. Citiz	zen of What (	Country?	
ozo vurs efter deeth v eft, or items 23s Examiner mulii by Funeral	11. Marital Status 1 ☐ Navar Mari 3 ▼ Widowed		Armed F ied 1 ☐ Yes If Yes, G	2 X No		Was Deced if Yes, spec	ity Cube	in, Mexicar	, Puerto	ecify Yes or N Ricen, etc.)		14. Race - An Black, Wi Specify: W	hite, etc.	in,
Ind A 12.15-00.20 be filed within 72 hours effer the lydine.  event, the Medical Examine  Be Completed by Fu	(Spe		st grade completed,		6e. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occup k done e retired	ation during mos d)	t of work	ing	16b. Kir	nd of Busines	ss/Industry	
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85=8			3 □Removal from	cem	etery, crer	sition (Nam matory or of ITAN	her plac	e) EMAT	ORY	Date -12/3		cation - City of EXAND		
permit. Pa Departmen Important: any injury atice.	21. Signature of Fr	-		۸	22		ONG	co.	, IN	C.FUN				
Physician /	23a. Part1. Enter shock, or hea		complications that only or a bause on	paused the death. I each Ine.	Do not ant	130 er the mode	O – e of dyir	N ST	REE	T, NW or respiratory	, WA arrast,	SH.,D	Approx	dmate il Between end Death
Examiner	disease or condition resulting in deeth)	on	\	SHOCK Due to (or es	s a consec	quence of):								DAYS
oscuted and al-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  RESPIRATORY FAILURE  Due to (or as a consequence of):  CARDIOMYOPATHY  C.  Due to (or as a consequence of):											DAYS		
The law requires that the death certificate be executed the has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit completed by Physician/Medical Examiner	Cause (Disease of that initiated event resulting in death)	errying r Injury is Last	c	CARDIOMYOPATHY  Due to (or as a consequenca of):									YE	ARS
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that the ed by the deteche	CORONARY ARTERY DISEASE								1 Yes 20(No 3 Probet			Probably	4 Unknov	
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The law te hes age 2										10	Yes X	□No	1 🗆 Yes	2 No
	25. Was cesa refa	rred to medical						26. Place	e of Dea	th (Check only	one)			
Physician: rthis certific and director,	exeminer? 1 \( \text{Yes} 2 \)	No	Hospitel: 1 🔀	Inpatient 2 ER	VOutpetier	nt 3 DO	A Oth	er: 4 N	ursing H	ome 5 Res	idence 6	6 □Other (S	pecify)	
g ag	27, Manner of Dee 1 X Netural 2 Accident 3 Suicide	th 5 Pendin Investig 6 Could a	pation not be ass place	of Injury 28	Bb. Time o Injury	М		yat k? Yes 2 □	No	28d. Describe	(Street an	d Number or	Rural Route	Number,
To the Hospital or Attendit within 24 hours and death. To the Funeral Director: A completely filled in by the t.	4 ☐ Homicide  29a. Certifier		build	ling, etc. (Specify)  best of my knowle				ne, date ar	nd place,		own, State,		as stated.	
No Ho	(Check only one)		Examinar: On the b	easis of examination nner stated.										use(s)
To the compound of the compoun	29b. Signature and	title of cartifie	ee W	. Keine	sh.	290	. Licans	2172	6			e signed (Mo EC • 29		
(3)		ress of person		se of death (Item 23			IRS	DR.	, R	OCKVI	LLE,	MD. 2	0850	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 4 2 7 2 5 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedant's Neme (First, Middle, Last) December 31. 1999 8:30 PM Langley Deda 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Prince George's Clinton Pineview Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2X F Deys Hours Yrs. 101 April 6,1898 Maryland 578-66-8227 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 M No Maryland Prince George's Suitland 10f. Zip Code 10g. Citizen of Whet Country? 20746 U.S.A. 3412 Aberdeen Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify White 3 ₩idowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 4th N/A Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Roberta Ching Alexander M. Lyon 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 3412 Aberdeen Street Suitland, Maryland 20746 John E. Langley (Son) 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) Jan. 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 2000 Suitland, Maryland 21. Signature of Funeral Service Licensi 22. Name end Address of Fecility Lee Funeral Home, Inc. M01095 6633 Old Alexandria Ferry Road Clinton, MD 20735 complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, by one ceusa on sech line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Pulmonary 48 hours Congestice Sequentielly list conditions, if any, leeding to immediate ceusa. Enter Underlying Ceuse (Diseesa or injury thet initiated evants resulting in deeth) Last Chronic Ulmonauy 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 20 No 24b. Ware eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of daeth? 1□Yes 2□No 2 No

**Physician** liviedium Examiner

**Physician** 

/Medical

Examiner

10e State

Directo

Funeral

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Completed

**Funeral** 

Director

the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if Item 27 is merked other than "naturel", or items 23a or 28a-f show with Injury or other treumetic event, the Medical Examples must be notified at once.

Baltimore, Maryland 21215-0020

Examiner physician end the burial-transit Physician/Medical 88 980 þ Completed page 2 Be 10 Certification:

signed by the a has certificate Aftar this filled in by 24 hours e completaly

certificata be axec P.O. Box 68760. Division of Vital Records, eftar death. Hospital

To the Within 2

Pert if Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Mannar of Deeth 28b. Time of Injury 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

> 29c. License number D42049

🗺 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and plece, end due to tha causa(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Xea) ] taway 3 , 2000

30. Neme and eddrass of person who complated ceusa of deeth (Item 23e) (Type, Print) Alan. G. CHAMPALOUX MD.

Upper Marlboro Mel

Registrar

29a. Certifler

(Check only one)

31. Dete filed (Month, Day, Year) JAN 0 4 2000 32. Registrer's Signature

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 1, 2726

				Ce	ertificat	e of	Death		Reg. No.	- Li	616	0	
		1. Decedent's Nema (First, Middle, Last	t)					2. Date of D	eath	W	3. Time of	Deeth	
	Physician	Marguerite Susar	nne LeRoy					Month Decemi	per 29,	Year 1999	2:00	a.m.	
	/Medical Examiner	4a Facility Neme (If not institution, giva	street and number)			4	lb. City, Town, or	_	-				
4		6515 8th Avenue					Adelphi		Princ	e Geo	rge's		
	Funeral Director	5. Social Security Number 6. Se 216–18–0603	7. Age (In yrs.	. last birthday Yrs.	Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D Feb. 6	rth ay, Year) , 1923	9. Birthp Copri Wash	lece (Stete o	r Foreign	
	8	Usuel Residence of Decedent											
	5-0020 72 hours after death with the Maryland natural, or hams 23s or 28e-f show stall Examiner must be notified at steed by Funeral Director	Maryland Prince Ge		ity, Town or t elphi	ocation				10d. Inside City Limit:				
		10e. Street and Number			10f. Zig	Code			itry?				
		6515 8th Avenue			20	783			U.S.A.				
020		11. Maritel Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes:	J,S. 13.	Was Dece If Yes, spe		ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	Bied	e - Americ ck, White, /: Whi	etc.		
9	2 ho lead	15. Decedent's Edu		16a. Dec	edent's Usu	al Occup	ation	and the same	16b. Kind of B	usiness/inc	dustry		
21	Baitimore, Maryland 21215-0020 emit. Pages 1 and 2 should be filed within 72 hours at bepartment of Health and Mental Hygiene. meortant: If them 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examinists. To Be Completed by F	(Specify only highest grad Elementery/Secondery (0-12)	Collega (1-4or 5+)	life.	DO NOT u	se retired	during most of wo	rking	Prince	Geor	ge's (	County	
2		12		Admi	Administrator				Liquor	Boar	d		
P		17. Father's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle					
/la		Phillip Ryan					(Unavai	lable)					
an		19e. Informent's Neme/Reletionship (T)	ype, Print)	19b. Mai	ling Addres	s (Street	and Number or R	ural Route Numi	ber, City or Town,	Stete, Zip	Code)		
		Cyril F. LeRoy -	Spouse	6515	8th	Aven	ue, Adel	phi, Ma	ryland 2	0783			
ore		20e. Mathod of Disposition	20b. I	Place of Disp cemetery, cn	osition (Na	me of other place	29)	Date	20c. Location -	City or To	wn, Stata		
Ĕ		1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	delitoval itom Stete					12/31/99	Silver	Sprin	ng, MD		
Balti		21. Signature of Funaral Sarvice Licens		1 2	22. Name er	nd Addre	ss of Facility				0,		
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	Physician /Medical	23a. Part1. Enter the disease, or complishock, or heert feilure. List only or immediate Cause (Final disease or condition	ne cause on each line.  Advanced Ch								Approximate Interval Bette Onset end I	ween Deeth	
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60,	ntificate be executed no physician and as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or es a conse	equence of):					1	130		
x 68760,	5 5 E	resulting in death) Last	Due to (d	or es e conse	equence of):								
Вох	death cer e attendin ed for use sician/N												
o	0 0 0	Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.							23b. Did tobacco use contribute to the cause of death				
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Division	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Special		treet, factor	y, office			(Street and Numi own, Stete)	ber or Rure	el Route Num	ber,	
	in 24 hours in 24 hours he Funer pletely fill edical		eician: To the best of my knowner: On the basis of examine end manner steted.									;)	
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	5	> X /	() Karon		T	2012	0		Dogombor	20	1000		
	10)	30 Name and address of account	ampleted gauss of death fire	m 22=1 /*		2012	9		December	. 3∪,	1999		
		A.A. Chacko, M.D.	ompleted cause of death (Net			90	Takoma T	Park Ma	rvland 2	0912	-6315		
	Ctoto	31. Data filed (Month, Dey, Year)	32. Registrar's Sign				9	GIR, Ha	Lyrana 2	.0714	0313		
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State of Maryland / Department of Health and Mental Hygiene QQ 1, 2727

					Certificate o	f Death	R	eg. No.	L	6161	
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	sician edical	Faye C. Lundy					Decembe			12:25PM	
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ter death	lera	11. Marital Status	12. Wes Decedent			of Hispenic Origin? (5 uben, Mexican, Puer	Specify Yes or No-	14. Rec	e - Americ	can Indien,	
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	5	1 Buriel 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specific			ry, cremetory or other p incoln Ceme		1/7/2000	Desc		- J MD	
Baltimo permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licer	-	110. 11	22. Name end Ad		Stewart			od, MD	
B S S S S S S S S S S S S S S S S S S S	d	TO	A T	777		enning Rd.				20019	
_		23a. Part Entar tha disease, or com	plications that caused	the deeth. Do						Approximete	
Dhualair	00	23a. Part . Entar tha disease, or com sho k, or heert feilure. List only	one ceuse on each li	ne.		, , ,				Intervel Between Onset end Deeth	
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rificate be executed ng physician and as the burial-transit	edical	that initieted events rasulting in death) Last	c. Oth								
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. 0 0 0	/slc	Pert II. Other significant conditions of	ontributing to death b	ut not resulting I	n the underlying ceuse	given In Pert I.	23b. Did to	3b. Did tobacco use contribute to the cause of deat			
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LIVISION  or Attending after death.  Director: Afte	ert	4 Homicide determined	building, et	c. (Specify)	, σιισοί, ισσισίγι		City or Town	n, Stete)			
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To the Hospital or / within 24 hours after To the Funeral Direct completely filled in the	edical		niner: On the basis of end menner ste	examinetion er	d/or investigation, In m	y opinion, deeth occi	urred et the time, d	ate end placa,	end due to	the cause(s)	
within 7 to the Comple	M e	29b. Signature and title of certifier			29c. Lice	ense number	2	9d. Date signe	d (Month,	Dey, Year)	
		Coonin	1110		D5	4550		12/3	1/9	9	
181		30. Nama and address of person who	completed cause of d	eeth (Item 23e)	(Type, Print)				1 (	4	
0		Christine Coer				r., Cheve	rly, MD	20785			
	State	31. Date filed (Month, Dey, Year)		er's Signeture			-				
	istrar	JAN 0 5 2000	Seper	nes 1	1. Loose	6.7					

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month December 29,1999 **Physician** 5:03AM Florence E. Mockabee /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10 M 20XF 80 579-14-2563 Feb.22,1919 Washington, D.C. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George Forestville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20747 7420 Marlboro Pike Funeral death Rems ; 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiens.

Important: if item 27 is marked other than "natural", or han eny injury or other treumatic event, the Medical Examinations. Black White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N.Y. School System Teacher Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 Pearl E. Posev Henry C. Mockabee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Bethany Loop Bethany Beach, DE. 19930 Maggie DeGeorge/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 12/31/99 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 also Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nook, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final RESPIRATORY FAILURE disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner PREUMONIA The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760, PREUMONIA ASPINATION physician Physician/Medical the Due to (or as a consequence of): signed by the attending I SEPTIC S14001C Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Unknown PLINEINEND DEMCNTIA Records, ģ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No this certificate Division of Vital Attending Physician: funeral director, 25. Wes case referred to medicat Be 26. Place of Deeth (Check only one) Hospitat: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No e Hospital or Attendil 24 hours after death. e Funeral Director: A plataly filled in by the fu death. 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated. To the Hosp within 24 hos To the Fune complately fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEC 29, 1999 chsenn BPYYEG carry

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TENRI 31. Date filed (Month, Day, Year) JAN 0 3 2000 Registrar

BAUME 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#8-102

Old BRANCH Are

MD

3000 E 0 MAL

#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth Month MALCZYNSKI **THERESA** ecember 4c. County of Death PRINCE GEORGES 4a Fscility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death LANHAM DOCTOR'S COMMUNITY HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours 1□ M 2日F 74 723-18-1408 Dec. 18,1925 Washington, DC Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 XYes 2 No BOWTE PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 12205 MARNE LANE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. 11 Marital Status Black, Whita, atc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Merried 1□ Yes 21 No Specify: WHITE Specify: 3 Widowed XX Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) DEFENSE DEPT. OF MANAGEMENT ANALYST 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) MARCHETTI ROSE ANTHONY COSTANTINO 19a. Informant's Name/Ralationship (Type, Print) GERALDINE E. TIMON/ daughter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) SAME AS 10 e 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata

Important: If item 27 is m any injury or other trsum once.

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

Completed by

Be

**Funeral** 

Director

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should be filed within 72 hours after ond Mental Hygiene.
marked other than "natural", or iter

1 and 2 should be Health and Mental

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Department.

Malezynski

**Physician** /Medical Examiner

Box 68760,

P.O.

Records,

Division of Vital Attending Physician:

After

death.

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Hospital

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24 hours after deat Funeral Director:

within 24 hor To the Fune completely fi

filled in

Physician/Medical þ Completed Be Certification: To

Examiner

20a. Mathod of Disposition ★Burial 2 Cremation 3 Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify) re of Funeral 0

23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on one hine. tmmediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last

CARDIOSEMIZ

Infan Myocardial

LIncoln Cemetery

22. Name and Address of Facility

Robert E. Evans Funeral Home , Inc Annapolis Rd., Bowie, Md. 20715

Biabeter Due to (or as a consequence of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 24a. Was an autopsy performed?

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

26. Place of Death (Check only ona)

24b. Ware autopsy findings available prior to completion of cause of death?

3 Probably 4 Unknown

Interval Between Onsat and Death

28d. Dascribe how injury occurred

Jah.3,2000 Brentwood, Md.

1 ☐ Yas 2 ☐ No

25. Was casa referred to medicat examinar? 1 Yas 2 No 27. Mannar of Death

3 ☐ Suicida

29a. Certifier

4 Homicida

1 Natural 5 Pending 2 Accidant

28a. Data of Injury (Month, Day Year) investigation 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b Time of

28c. Injury at Work? 1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signetura and titla of certifier Unatruth-

29c. License number 52119 29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Chatrathi Sridhar 31. Deta filad (Month, Day, Year) JAN 0 3 2000

3100 Good luck Road Suito 302 Lanham Mol 20706 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

3 2000 E 0 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death NECEMBER Day Alfred John 1800 Mozier 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death TEMPLE HILLS 6417 MORTON PLACE PRINCE GEORGES If Undar 1 Yaar If Undar 24 Hrs. 6 Sax 7. Aga (In vrs. last birthday) Birthplece (Stata or Foreign Country) 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Months Days Hours XXM 2 F 67 Yrs. 196-24-8985 March 10,1932 New Jersey Usual Rasidanca of Dacedant 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Prince George's Temple Hills 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 6417 Morton Place 20748 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? ▼XXXes 2 □ No 17 195, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Narried 1 Yas 2 XNo Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantery/Secondary (0-12) Collana (1-4or 5+) Sergeant Major Ret. United States Army 18. Mothar's Nama (First, Middle, Meiden Surnama) 17. Fathar's Nama (First, Middla, Last) Warden Alfred John Mozier Florence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Sue Ying Mozier (Wife) 6417 Morton Place Temple Hills, Maryland 20748 20a. Mathod of Disposition
1 □ Burlal 2 Boramation 3 □ Ramoval from Stata 20b. Placa of Disposition (Nama of cematary, crematory or other place) 2000 20c. Location - City or Town, Stata 6, Jan. 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory 21. Signature of Funeral Service Links 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, Maryland wood 20235 s that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part1. Enter the disease, or con shook, or heart failure. List only intarval Batwaan Onsat and Death Immediata Ceuse (Finel CANCER OF disaasa or condition rasulting in daath) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseesa or injury thet initiated events rasulting in daath) Last Due to (or es e consequence of) Dua to (or as a consequanca ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to 24a. Was an autopsy complation of causa of death? N/A 1 Tyas 21 No 1 ☐ Yas 2 ☐ No 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Assidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner thet the death certificate be executed

permit. Peges Department of Important: If It any Injury or c

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

"natural", or items 23s or

Peges 1 and 2 should be filed within 72 hours effer or and of Health and Mentel Hygiene.

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Examiner physician end the burial-transit Physician/Medical signed t þ Completed i certificate has t lirector, page 2 s Be Certification:

P.O. Box 68760.

Division of Vital Records,

law. 4 Afflet Athending death Director atter A Funeral D Hoons

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Medical

State

Registrar

25. Wes case rafarrad to medical examinar? examinari 1 Yas 2 No 27. Menner of Deeth 1 Naturel 2 Accidant

4 Homloide 29a. Cartifian

3 ☐ Suicida

5 Panding Invastigation

6 Could not be datarmined

28a. Data of Injury (Month, Dey Yaer)

28a. Placa of Injury - At homa, farm, straat, fectory, office building, etc. (Specify)

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

DRIVE.

 Location (Straet and Number or Rural Routa Number, City or Town, Stete) 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated.

Madical Examinar: On tha basis of axamination and/or invastigetion, in my opinion, deeth occurred et the tima, date and place, and due to the ceuse(s) and mannar statad.

29b. Signature

29c. Licansa number

29d. Data signad (Month, Dey, Year) DECEMBER 31, 1990

CHEVERLY MARYLAND 2078S

(Isam 23a) (Type, Print) 30. Nama and addrass of person who complained causa of deal MAPLO P GOLLE

M 32. Registrar's Signatura

31. Data filed (Month, Day, Year) JAN 0 4 2000

**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedant's Name (First, Middle, Last) Day **Physician** 1725 30 DECEMBER May John James /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Daath **Examiner** 11912 5LMW00D BRANDYWINE PRINCE GEORGES DRIVE 7. Age (In yrs. lest birthdey) 62 Yrs if Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth November Day 6 year 937 9. Birthplace (State or Foreign Wastrangton DC 5. Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Yrs. Director 578-48-2972 Usual Residence of Deceden with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Marical Examiner must be notified at Brandywine 1 Yes 2 No Maryland Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20613 11912 Elmwood Drive pemit. Peges 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - Amarican Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 4+ Budget Analyst 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Mildred Fitzhugh Lo James John May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11912 Elmwood Drive Brandywine, Maryland 20613 Angelina May (Wife) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4,2000 Jan. 4 Donation 5 Ofhay (Specify) Resurrection Cemetery Clinton, Maryland 21. Signature of Funeral Service License 22. Name and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and aach lina. 23a. Par(1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Betwean Onset and Death **Physician** Immediate Cause (Finat disaase or condition resulting In death) /Medical \* ARTERIOSCIEROTIC CAPPIO VASCULAR DISEASE Examiner Due to (or as a consequanca of): Examiner certificate be executed ician end buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that Initiated events rasulting In daath) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the Dua to (or as a consequence of): 88 USB 0 23b. Did tobacco uss contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed page 2 hes N/A 1 ☐ Yes 2 No 1 TYes certificate Division of Vital or Attending Physician: director. Be 25. Was case raferred to medical 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending efter death. 1 Yes 2 No Invastigation 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) filled in by 4 Homicida 24 hours Hospital edical 29a. Cartifier 🗀 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha causa(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner. (Check only one) To the To the I 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

Itam 23a) (Type, Print)

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32. Registrar's Signatura

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DECEMBER 31, 1999

State Registrar 30. Name and address of person who co

31. Date filed (Morth, Day, Yeer)

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42732 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physician
	/Medical
	Examiner
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Funeral

Director 6 "natural"

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Hygiene. other other traumatic event, Peges 1 and 2 should be fill ment of Health end Mentel Hitamst If Item 27 is marked oth Department of Important: If It eny Injury or o

**Physician** /Medical Examine

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Examiner the buriel-transit Pue ettending physicien Physician/Medical US0 081 P Completed this certificate has director. 8 funeral After

The taw requires that the death certificate be executed or Attending Physicien: i efter death. I Director: Aft d in by the fur filled in by To the Hospital o within 24 hours of To the Funerel Di completely filled in

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day John William McDevitt 1999 08.16 AM December 30 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Lanham Doctor's Community Hospital Prince George's If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Months 1⊠M 2□ F 60 577-50-1410 June 13, 1939 Washington, D.C. **Usual Residence of Decedent** 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Riverdale 1 ☑ Yes 2 ☐ No Prince George's Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20737 5908 Cleveland Avenue 12. Was Decedent Ever in U,S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 🖾 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Town of Riverdale Elementary/Secondary (0-12) College (1-4or 5+) 10 Driver Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Royce McDevitt Gladys Blacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Royce McDevitt - Brother 5908 Cleveland Avenue, Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 1/5/00 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gasch's Funeral Home 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) HRS RESPIRATORY FAILURE MAUGNANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy tindings avellable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation Natural 1 TYes 2 TNo 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 296. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) varam D. Welter D23743 1-2-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State

Registrar

MARTIN D

31. Date filed (Month, Day, Year)

JAN 0 4 2000

32 Registrar's Signature

7525 GREENWAY CTR DR, GREENBELT.

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			C	ertificate of	Death		Reg. No.	4 2 7 3 3	al.		
cian	Decedent's Neme (First, Middle, Last		7			2. Date of De Month	Day	reer			
ical iner	EVERETT D.  4a Facility Neme (If not institution, give	MASTERSON e street and number)	N	T	4b. City, Town, or	December Location of Deet			1		
	Washington Advent				Takoma P			ntgomery			
1	5. Sociel Security Number 6. S	ex 7. Ag	e (In yrs. lest birthd	Months   Davs	If Under 24 Hrs Hours Min.	8. Date of Bit (Month, Da	rth ay, Year)	Birthplace (State or For Country)	eign		
	577-22-1369 Usuei Residence of Decedent		78	•		Oct. 22	i, 1921 W	ashington Do	3		
	10a, Stete 10b. County		10c. City, Town o	Location				10d. Inside City Lin			
Director	Maryland Montgome	ry	Silver	Spring				1⊠ Yes 2□	No		
	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	net Country?			
	7051 Carroll Aven	ue, #203	Ever in U.S.		2-4412 Hispanic Orlgin? (S	Specify Yes or No	U.S.A.	- American Indian,			
	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Yeer or Dates:	No	3. Was Decedent of if Yes, specify Cut 1 ☐ Yes 2 ☑ No		to Rican, etc.)		, White, etc. Black			
	15. Decedent's Ed (Specify only highest gra-		(6	ecedent's Usuel Occu	during most of wo	rking	16b. Kind of Bus				
l	Elementary/Secondary (0-12)	College (1-4or 5	i+)	e. DO NOT use retire	ed)		General	Services Adı	nin		
l	9th 17. Fether's Name (First, Middle, Last)		Lab	orer	18. Mother's Na	me (First, Middle	, Maiden Sumeme	)			
I	Julius Masterson				Rosa Da	vis					
	19a. Informent's Neme/Relationship (7	**						or Town, State, Zip Code)			
nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified as any of the traumatic event. To Be Completed by Funeral Director	Toni Farmer - Dau	ghter		1 Parade S	St., Erie			7 T			
l	20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 3 ☐		cemetery,	cremetory or other pla	,	Dete		ity or Town, Stete			
Important: if item 27 any injury or other to pncs.	4 □ Donetion 5 □ Other (Specify  21. Signeture of Funerel Service Licen	·	FORT L	ncoln Cem	-			d, Maryland			
	21. Signeture of Funeral Service Licensee  22. Name end Address of Facility Marshall's Funeral Home, Inc.  4217 9th Street N.W. Washington DC 20011										
+	23a. Part1. Enter the disease, or companion, or heart failure. List only	plications that caused	the death. Do not					Approximate Intervei Between			
signed by the ettending physician end in possion of be detached for use as the burial-transit in possion of by Physician/Medical Examiner	Immediate Cause (Finel disease or condition resulting In death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	C	Due to (or as a cor	sequence of):	u cr	72					
	Pert II. Other significant conditions co	ontributing to death b	ut not resulting in th	e underiving cause g	iven in Pert I.	23b. Did	tobacco usa cont	ribute to the cause of de	ath?		
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pe completed							Yes 2₺No	1 ☐ Yes 2 ☐ No			
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospitai:	int 2 ER/Outpe	etient 3 DOA	ther	ath (Check only	one) idence 6 □Othe	(Specify)			
	27. Manner of Death    Maturai 5   Pending investigation	28a. Date of inju (Month, Date	ry 28b. Tim	e of 28c. Injury	ury et ork?	28d. Describe	how injury occurre	od .			
	3 Suicide 6 Could not be 4 Homicide determined	28e. Piece of injusting, etc.	ury - At home, farm c. (Specify)	, street, fectory, office			(Street end Numbe own, State)	r or Rural Route Number,			
within 24 hours effet death. To the Funeral Director: After t completely filled in by the funer Medical Certification:											
oute	one)			29c. Licer	nse number		29d. Date signed	(Month, Dey, Year)			
	29b. Signature and title of certifier			A	-/- 1		1 (2 / 3				
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Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month DECEMBER 28, 6:08 PM 1999 DENNIS (NMN) MCBRIDE 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Bethesda

If Under 24 Hrs.
Hours | Min. | 8. Dete of Birth (Month, Day, Year) | February 8,1949 | Betaware National Institute of Health If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 1₩ 2□ F Months Deys 221-34-6231 50 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 A Yes 2 No Delaware New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 W 22nd Street 19802 U.S.A. 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: White If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+)
5 + Private Practice Attorney 18 Mother's Name (First Middle Malden Sumame) 17. Father's Name (First, Middle, Last) George J. McBride Rita Dennis 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Patricia McBride - Wife 702 W 22nd Street, Wilmington, Delaware 19802 20b. Plece of Disposition (Neme of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removel from Stete All Saints 1-3-00 Newark, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. Marst 4217 9th Street N.W. Washington DC 20011 Pind. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, bock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting In death) JEAS,S Due to (or as a consequenca of): entre worrow Due to (or as e consequence of): 23 years noma Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? disease 1 Yee 2 No 3 Probably 4 Unknown au ter 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy

**Physician** /Medical **Examiner** 

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Division of Vital Records.

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**Funeral** 

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Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

coronar

1 Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 No

25. Was cese referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth

28a. Date of Injury (Month, Day Year) 5 Pending

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier

1 Natural

2 Accident

3 ☐ Sulcide

4 Homleide

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier

investigetion

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pelz

Robert K 31. Date filed (Month, Day, Year)

JAN 0 4 2000

32. Registrar's Signature

MD

9000 ROCKVILLE PIKE, BETHESDA, MD 20892

Registrar

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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physician** LOUISE NEUBEN DECEMBER 30, 1999 11:10 AM /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) 1916 Birthplace (State or Foreign VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months | Days Hours 10 M 20 F 227-28-0768 83 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 BNo Director MARYLAND FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norma 23a 1001 CARROLL PARKWAY APT 406 Funeral 21701 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 to No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 72 hours after 1 Nevar Marriad 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: þ WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be in Department of Health and Mental important: If Item 27 is marked or any injury or other traumatic eve ROBERT HORNE 2 POLLIE SEXTON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 202 CRAMER AVENUE, WALKERSVILLE MARYLAND 21793 JERRY DUBE 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 1-5-2000 BRENTWOOD, MARYLAND 21. Signature of Funerel Service Licenses 22 Name and Address of Facility FORT LINCOLN FUNERAL HOME INC uhen alsw 3401 BLADENSBURG RD, BRENTWOOD MD 20722 23a. Pert1. Enter the disaesa, of complications that caused the death. Do not enter the mode of dylng, such es cardiac or respiratory erreat, shock, or heart failure. List only one cause on each line: Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final diseasa or condition resulting In death) /Medical CARDIOGENIC SHOCK Examiner Due to (or as e consequence of): Examiner Mitral ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in deeth) Last Due to (or es a consequenca of): Block 36 physician s the burial Complete to L Box 68760. Physician/Medical Dua to (or as a consequence of): nfera Myocardial infuchas Wall P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown DIABLTES Records. A Pg 8 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 1 Yes 2 No 1 Tyes 2 THO Division of Vital Attending Physician: Be 25. Was case ratarred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 DNatural 5 Pending 1 Yes 2 No death. 2 Accident invastigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide ò Hospital 29e. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as atated To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 54616 30 December 6 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 9th SHAWN BUKI 310 St 2170 31. Dete filed (Month, Dey, Year) Registrer's Signetura State JAN 0 4 2000 Registrar

JAN 6 - 2000

attention of the following

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Deta of Death 3. Time of Death Month **Physician** 6:05 Am December 29 1999 Barbara Jean Price /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Min. 1 M 2 F Months Days Hours Director 578-90-8515 42 Oct.13,1957 Indiana Usual Residenca of Decedant 10s. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director 28a-f Md. Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 683 Frost Valley Lane 21054 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forcas?
1 ☐ Yes 23∑ No ff Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 287 Married b 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) 86 Pages 1 and 2 should be nent of Health and Mental Thomas Clary Virginia Blair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Christopher Price/Husband 683 Frost Valley Lane Gambrills, Md. 21054 20b. Placa of Disposition (Name of cametery, crematory or other placa)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State Data 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 12-31-99 Alexandria, Va. Crematory 1
22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee Shannon W. Beall Beall Funeral Home 6512 N.W. Crain Highway Bowie, Shannon W. Beall M00798 Md. 20715 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition rasulting In death) Examiner Examine The law requires that the death certificate be assecuted burial-transit Sequentially list conditions, if any, leeding to immediate cause. Entar Undarfying Cause (Disease or injury that initieted events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 20 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate has 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa raferred to medical examiner? Certification: To Be 26. Piaca of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) uneral 28b. Time of injury After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 29e. Certifier Medical 🅊 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end dua to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 10 Bunne. 301 Hostal JUDIEN Gregung 31. Date filed (Month, Day, Year) State JAN 0 3 2000 Registrar

**ORIGINAL** 

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**DHMH 16 Rev 6/95** 

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Physicia			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month December 30,19		3. Time of Death 1:35 PM	
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	Examiner	Holy Cross Hos				Silver S			ntgom	ery	
	Funeral Director	5. Social Security Number 578-16-6738 1	M 22 F 7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 7/19/	th Venr) 16	9. Birtho Coun Penn	place (State or Foreign htry) Co., Va.	
	Maryland 4 show led.at	Usuel Residence of Decedent  10a. State 10b. County Md. Prince Geo		City, Town or Loc Clinton	cation				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	her death with the Maryland flerre 23s or 28s-f show line, must be notified at Furneral Director		y Rd.		10f. Zip Code 20	735		10g. Citizen of	Whal Coun	•	
020	at, or he bamine by Fur	3 ☑ Widowed 4 ☐ Divorced	2. Wes Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	tispantc Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Re- Bis Specii	ce - Americack, White, of		
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land 2	Hall H	17. Falher's Name (First, Middle, Last)	e			18. Mother's Name	<i>(First, Middle,</i> irdia S		ne)		
, Mary	2 abd all and	19e. Informent's Neme/Relationship (Ty) Georgia Hogue/Siste	oe, Print) Y	19b. Meilin Same	g Address (Street as # 10	and Number or Rura above	I Route Numbe	er, City or Town	, State, Zip	Code)	
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Balt	Depart Depart Import any in	21. Signature of Funeral Service License		4	Name and Addre H.S.Wash 925 Burr	ington & soughs Ave	Sons Co	.,Inc. Wash.,D	.C. 2	.0019	
	Physician /Medical Examiner	b b	ESOPHA C	GEAL (or as a consequ		NOMA			F	EW YEAR	
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	at the death certified by the attending letached for use a Physician/M	Part II. Other significant conditions conf	ributing to death but not n	esulting in the un	derlying cause gi	ven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?	
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	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the Medical Certific										
	To the comp	29b. Signature and little of certifier	you, M.D.		29c. Licens	se number S 2 931		29d. Date sign		Dey, Year) 50,1999	
	4)	30. Name and address of person who cor	s, IIII9 Roc	KVILLE	PIKE, S	UITE 100	ROCKY	ILLE M	D 50	822	
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State of Maryland / Department of Health and Mental Hygiene 99 42738

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 30, Elizabeth Anne Ritter Dec. 1999 2:49 am /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Arundel Anne If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 1 □ M 210 F Washington, Yrs. Director 26 Sept. 16, 1973 2-17-0682 D.C. Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show 1 ☐ Yes 2 No Director Md. Queen Anne Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Examiner must be "natural", or items 23s Funeral 108 Birch Road 21666 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Meritei Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 4 Sales Associate Retail permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: if less 27 is marked. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 98 2 David Lawrence Ritter Laura Lee Everly 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Lee Ritter/Mother 108 Birch Road Stevensville, Md. 21666 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Stevensville Cem. 01+05-00 Stevensville, Md. 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Shannon W. Beall Beall Funeral Home Shannon W. Beall M00798 6512 N.W. Crain Highway Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician 01 G /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 6 burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and physician s the burial Box 68760 Physician/Medical Due to (or es e consequence of): 60 P.O. | signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 2☑No 1 Yes 1 □ Yes 2 □ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Netural 5 Pending hours after death. ineral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled. edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Item 33a) (Type, Print)

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Dey, Year)

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32: Registrer's Signature

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day RIDGEWAY FUNICE BLAND 30, 1999 December 11:34am 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death LaPlata Civista Medical Center Charles 8. Data of Birth (Month, Day, Year) June 3, 1908 If Under 1 Yaar 9. Birthplace (State or Foreign 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Days Hours 1□M 2□F Months Virginia 91 215-48-1874 Usual Rasidence of Decedan 10d. Inside City Limits 10a, Stata 10b. County 10c. City. Town or Location LaPlata Yes 2□ No Charles Md. 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20677 USA 6585 Horseshoe Drive 12. Was Decedant Evar in U,S. Armed Forces? 1 Yas 2XXX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married White 1 ☐ Yas 2 ☐No Specify: If Yas, Giva Year or Datas: Specify: 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Myrtle Marks Thomas Allen Jenkins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) S.R. 5, Box 395 C-1, LaPlata, Md. 20646 Dennis L. Thrift/ grandson 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Removal from Stata Welcome Grove Baptist Cem. Jan. 2,2000 Newland, Va. 4 ☐ Donation 5 ☐ Othar (Specify) of Funera 22. Nama and Address of Facility ROBERT E. EVANS FUNERAL HOME, INC 16000 BOWIE, MD. 20715 ANNAPOLIS RD. Approximate Interval Between Onset and Death 23a. Part1. Entar tha disaase, or complication shock, or haart faitura. List only ona one that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, to on each line. Immediata Causa (Finat disaase or condition resulting in death) Due to (or #\$'a consequence of) Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury Dua to (or as a consequence of): that initiated evants rasulting in death) Last Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Ves 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical 26. Place of Death (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 | Inpatient 2 ER/Outpatient 3 □ DOA

**Physician** /Medical Examiner

Box 68760

P.0.

Records,

Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Nems 23a

"natural", or

permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event.

Director

Funeral

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Completed

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other traumatic event, the Medical Examiner must be notified at

A 10/5 8 WAY Maryland 21215-0020

Examiner Physician/Medical þ Completed Be 2 Certification:

attending physician and for use as the burlal-transit that the death certificate be executed 8 2 signed t should should certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical funeral

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Registrar

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifier

27. Manger of Death

1 Naturat

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29a. Certifiar

5 Pending invastigation

6 Could not be detarmined

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) George H. Wathen, MD

Waldorf, Maryland 20603

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

D - 20629

Pembrooke Square, Suite 103

1 Yas 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

3

32. Registrar's Signatura JAN 0 3 2000

28a. Date of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

3AN 0 & 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) DECEMBER 30, 1999 1700 Robert Anthony Rosekrans, Jr. PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) BOWLE PRINCE GEORGES 3505 Malec Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 110 M 2□ F Yrs. 117-26-3009 64 03-28-1935 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 3505 Malec Lane 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 XYes 2 No 1956 -If Yes, Give Year or Dates: 1958 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 1958 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Anthony Rosekrans, Sr. Grace Keenan 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Vineyard Court Crofton, Md. 21114-1133 Gerard Rosekrans/Brother 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-05-00 Clinton, Maryland Resurrection Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Shannon W. Beal Beall Funeral Home Snannon W. Beall M00798 6512 N.W. Crain Highway Bowie, shock, or heart feilure. List only one cause on each line. Md. 20715 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OF MOUTH Due to (or as a consequence of) Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Md.

**Funeral** 

**Director** 

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permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Heelith and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a
any Injury or other traumatic event, the Medical Exercises 23a
any Injury or other traumatic event, the Medical Exercises 23a

the Maryland r 28a-f show

> Examiner physician end the bunal-transit Physician/Medicai 88 usa by Completed Be 10

Box 68760. the death certificate be signed by the a thet irector, page 2 s Physician: this Affar or Attending r death. Director: A 6 hin 24 hours after the Funeral Direction after Hospital

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Division of Vital Records.

Medical To the lithin 2 to the l

Registrar

Certification:

29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

DAVE CHEVERLY

eted cause of death (Item 23e) (Type, Print) 30. Name and address of person who F. Golle

MARIO 31. Date filed (Month, Day, Year) JAN 0 4 2000

27. Megner of Deeth

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homlcide

MD 3001 32. Registrar's Signature

College States

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 1,271,2 State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death AMENDED ITEM #19a PER FH G781 3/7/2000 AH 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death December 23, 1999 Eversfield Swann **Physician** 22:30 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 8. Dete of Birth (Month, Day, Year) Tahon 9, 1952 If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. Jast birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min 1X M 2□ F Yrs. 219-58-8126 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show eny injury or other treumatic event, the Modesi Examinal must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits SUitland Prince George's Maryland MX Yes 2 □ No Directo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 4699 Homer Avenue Apt. #C 10f. Zip Code 20746 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Maritel Stetus Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use ratired) Student Collega (1-4or 5+) Elementary/Secondary (0-12) Barber School 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Joseph M. Swann Harriett Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs. Harriett Dixon (Mother) 1618 Quarter Avenue Capital Heights, Maryland 20743 20b. Place of Disposition (Name of 20a. Method of Disposition Conton, Mary Tand State 1/392000 1 Burial 2 □ Cremation 3 □ Removal from State Forest Hills Memorial Gardens, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility ROTTINS FUNETAL HOme, Inc. 21. Signature of Funeral Service Licanses 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the risease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Cause (Final disease or condition rasulting in daath) /Medical Examiner re Respiratory Feilure poxemie Examiner and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest ettending physician a for use es the buriel-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the e 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4X Unknown þ 24b. Wera autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes b 1 Yas 2 No 1 Tyes 2 XNo or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 No 1 ☑ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending 1 TYes 2 No investigation efter deeth. Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in 24 hour. the Funeral Directory filled in by 6 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b Signature and title 29c. License number

2

Joseph Colella, M.D.

31. Date filed (Month, Day, Year)

JAN 0 3 2000 32. Ragistrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital Drive Cheverly, Maryland
32. Registrar's Signature

6. Apartal

20785

State

Registrar

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### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene 9 4 2744

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27. Mannar of Death   2   ER/Outpatient   3   DOA   28c. Injury at Work?   2   Accident   3   Suicide   4   Homicida   28c. Outpatient   28c. Injury at Work?   1   Yes   2   No   28c. Injury at wo	actor, Be	eveminar?				T. C.	e of Deeth (Check	only ona)			
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30. Name and address of person who completes cause of death (Item 23a) (Type, Print)	1.1	30 Name and address of plans who o	ompleted house of death /	lom 23a) (Tues	a Priest\	رارو سن					

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month **Physician** BEULAH M DECEMBER 27, 1999 8:08 PM /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES 7. Age (In yrs. last birthday) 62 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Min. Hours Director 214 58 4842 1937 NORTH CAROLINA Usual Rasidance of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes ZNo Director MARYLAND PRINCE GEORGES CAPITAL HEIGHTS 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 203 ð 20743 UNITED STATES 6018 MARTIN LUTHER KING HIGHWAY APT flems 23s Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Armed Forces?

1 Yas 2 No
If Yas, Giva
Yaer or Dates: 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ğ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working tife. DO NOT use retired) Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Pages 1 and 2 should be vent of Health and Mental CARL COOK VIOLA ATKINS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE SMITH 7017 PALAMAR TURN, LANHAM MARYLAND 20706 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removal from State FORT LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 1-4-2000 BRENTWOOD, MARYLAND 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME INC
3401 BLADENSBURG RD BRENTWOOD MD 20722 21. Signatura di Faneral Service Licenses erture 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on aecit line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediata Causa (Finel diseesa or condition rasulting in daath) Examiner Examiner UNG CAMC physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last STACIE Box 68760. Physician/Medical Dua to (or as a consequence of) for use as USB 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown -15 m Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? **page 2** 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Horna 5 Residence 6 Other (Specify) 2 1 Department 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Deta of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After Division or Attending 5 Panding invastigation I hours after death.

uneral Director: Aft
ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida To the Hospital o within 24 hours at To the Funeral Di completely filled is edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only 29b. Signature and Island certifie 29c. License number 29d. Data signed (Month, Day, Year) D 30666 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print) 1450 MERCANTILE LANGE, LARGO MO JOHN W. BEDEAU 32 Řegistrar's Stghatura 31. Data filed (Month, Day, Year) State JAN 0 4 2000 Registrar

DHMH 16 Rev 6/95

JAN C & 2000 James & April

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Emmett Sheahan December 28, 1999 7:40 pm 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 13214 Ronehill Drive **Beltsville** Prince George's if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ₽ M 2 □ F Months Days 577 60 5858 84 Yrs. June 5, 1915 Wash., DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Calvert North Beach 1 TYYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9131 Frederick Avenue USA 20714 12. Was Decedent Ever in U,S. Armed Forces? 1 ੴ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 X Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specity: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 mail\_clerk US Postal Svc. 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) Timothy Joseph Sheahan Mary Frances Garner 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda)

Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Mary Margaret Cornwell/neice 15301 Beaverbrook Ct., Apt. 3D, 200. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Mt. Olivet Cemetery 1-3-00 Bladensburg, MD 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, Owings, MD 20736 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death Dancientic (ancer Immediate Cause (Final diseasa or condition resulting In death) Dua to (or as a consequence of): Sequentielly list conditions, if any, laading to immediate ceusa. Entar Underlying Cause (Disease or Injury that Initiated avants resulting in daath) Last Dua to (or as a consequence of): Due to (or as e consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably WUnknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa rafarrad to medical examiner? 26. Placa of Daath (Check only ona) Brother's home Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) 29a. Cartifiar (Check only one)

that the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

signed i cartificata hes birector, paga 2 s Hospital or Attending Physician: 24 hours aftar deeth. Funeral Director: Aftar this carifice funarel in 24 hou... the Funeral Direction of filled in by To the Hosp within 24 ho To the Fune completaly fi

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

with the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examine must be neutral analoga.

**Physician** 

/Medical

Examiner

physician and tha burial-transit

5 usa

Examiner

Physician/Medical

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Completed

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Certification:

Medicai

Baltimore, Maryland 21215-0020

1 VA 20

> State Registrar

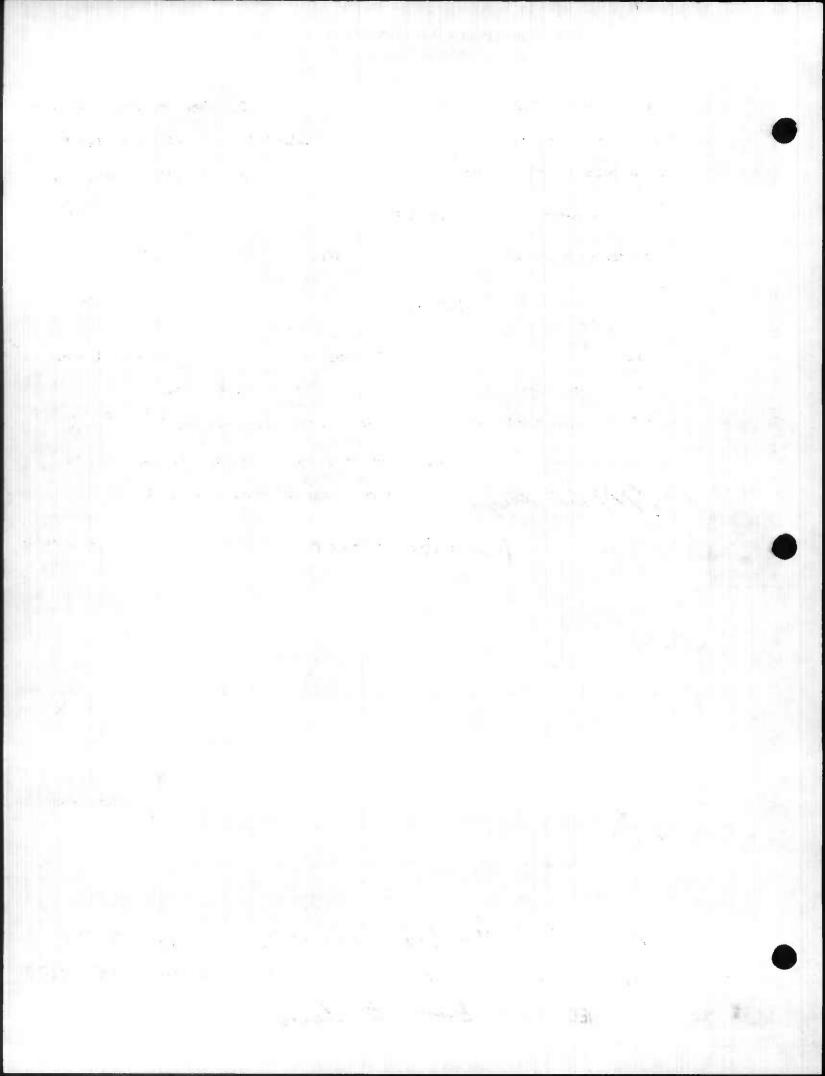
29b. Signature end title of certifier

and manner stated

29d. Date signed (Month, Day, Year)

Name and address of parson who completed ceuse of death (Item 23a) (Typa, Print) ACRD, PRINCE FREDENICK, UPD, 20678 RRUCE

31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 3 0 1999 ▶



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12 NWOOD /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Brantley Norcester va c If Under 1 Year 9. Birthplace (State or Foreign Country) Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours -80 1 M 2 F Yrs Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland name of Health and Mental Hygiene. International Health and Mental Hygiene. "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or heme 23a or 28a-f show 1 ☐ Yes 2 No **Funeral Director** acomo 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 36 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 NNo If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Mantal Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No Specify. by 3 ☐ Widowed 4 ☐ Divorced lack Yeer or Dates: Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other than "I r traumatic avant, me Hea Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) abor TUTMING 18. Mother's Name (First, Middle, Maiden Sumame) humas ais 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) ity, Md. 2 10, Box 20 IQA 000 important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1. Burlal 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stackton Lemetar 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith Funoral I 23a. Parti-Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hom Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner sician and burial-transit or Attending Physician; The law requires that the death certificate be assouted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Records, P.O. Box 68760 ASUVA Physician/Medical Due to (or as a consequence of): been signed by the attending p should be detached for use as 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? cate has l 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) fiiled in by 4 Homicide Hospital 29a. Certifier edical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00

Registrar

10

State

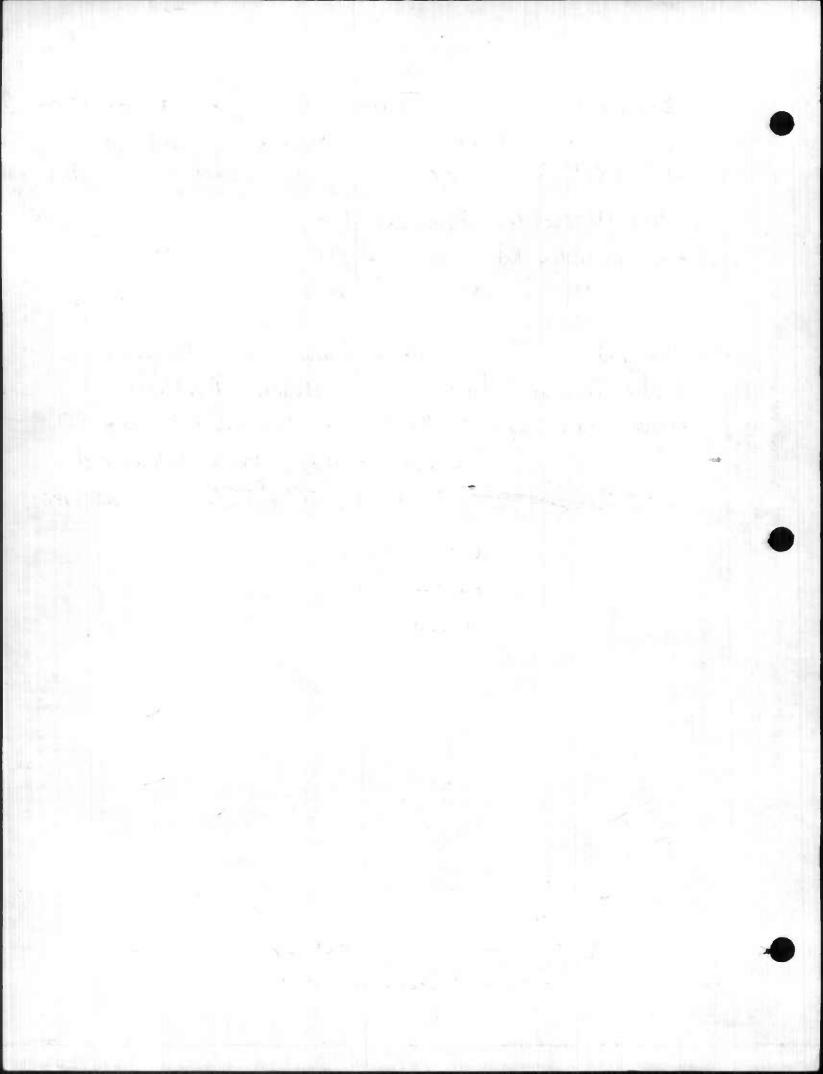
30. Name and address of person

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

072000



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 24, 1999 12:43 AM **Physician** GERTRUDE TANNER /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Regional Hospital Laurel If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min. 1□ M 2₩ F 103-01-8323 Yrs. 80 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Howard Jessup Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be 8229 Washington Blvd., #8 20794 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ White 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other trainment of the t General Services Elamentary/Secondary (0-12) College (1-4or 5+) Administration Telephone 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hewitt Helen Litchmounger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Valerie Hope Tanner - Niece 8229 Washington Blvd., #8, Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/05/00 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 noc 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata intarval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Few Days Examiner Examiner Cardrae arresi physicien end the burial-transit Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Resporalery P.O. Box 68760. death certificate be Physician/Medical Due to (or as a consequence of): use as t ed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably JUnknown signed t Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Panding 1 Yes 2 No 24 hours efter death. investigation 2 Accident 6 Could not be datermined 28e. Place of fnjury - At home, farm, street, factory, office building, atc. (Spacify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Cartifying Physician: To tha best of my knowledga, death occurred at the tima, date and place, and due to the ceusa(s) and mannar as stated. 29a. Certifier edicai completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 042580 muleno 30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print)

AUTH \$232 Annapolis Ra #13 Resposais Bernel no 2010

State Registrar

JAN 0 4 2000

31. Date filed (Month, Day, Year)

32. Ragistrar's Signature
Server G. Sparls

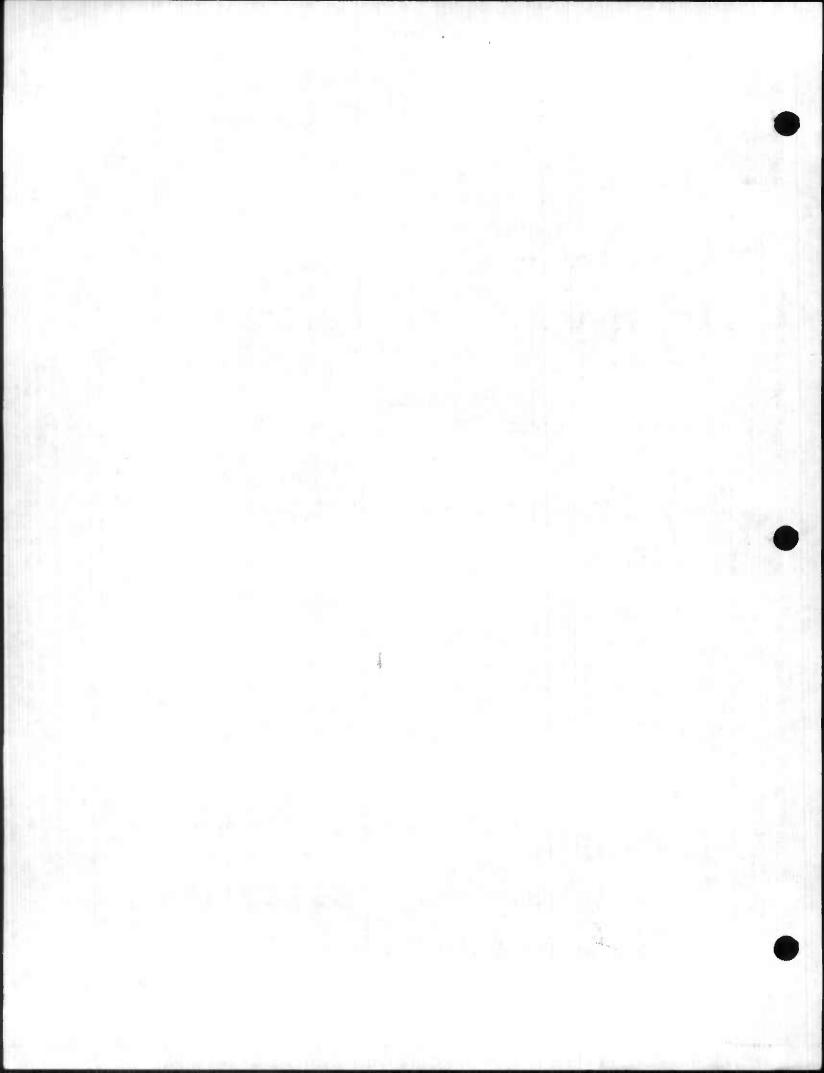
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

Cavin D. Wilson

AMEND ITEMS: #23 PART I, 27 PER MEO G780 2 Certificate of Death

	100. 1/25 TAKE 1, 2		Certifica	te of Death		g. No.	a William of Donat			
Physician /Medical	1. Decedent's Name (First, Middle, Last Cal Vin	D	wilso		2. Dete of Deeth Month Decembe	r 31, 19	99   12:40 P			
Examiner .	4a Facility Name (If not Institution, give 24459 Nanticoke			4b. City, Town, or Quantic	Location of Death	4c. County of D				
Funeral Director	239-98-0014	7. Age (In yrs.	last birthday) If Und Months	er 1 Yeer If Under 24 Hr. B Deys Hours Min			Birthplece (State or Fore			
thems 23a or 28a-f show one must be notified at uneral Director	Usual Residence of Decedent  10a. Stefe 10b. County  MUCOM	1	Town or Location				10d. fnside City Lin 1 ☐ Yes 2			
the no	10e. Street and Number 24459 Nanti	coke Rd	10f. Z	ip Code 2 / 8 5 6	10	og. Citizen of What	Country?			
Frame by F	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	S. 13. Wes Dec	edent of Hispenic Origin? (ecity Cuban, Mexicen, Pue	Specify Yes or No- rto Rican, etc.)	14. Rece - A Bieck, V Specify:	merican Indien, white, etc.  Black			
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variand offin nelic event To Be C	CALVIN G. 6	WISON		CAthe	., ., .	ma 4th				
or other traum	19e. Informent's Neme/Reletionship (Inc.)  20e. Method of Disposition  Buriel 2 Cremetion 3	ISON FAHO	24459 lece of Disposition (N	other place)	Rel Que	entice,	mel 2185 or Town, State			
Important any injury ance.	4 Donetion 5 Other (Specification of Funeral Service Licentification of Funeral Servic		22. Name	BAN CH.  and Address of Facility  The Robert	NERN H	time (	/a 23301			
ysician Nedical aminer	23a. Part1. Enter the disease, or com shock, or heart tailure. List only immediate Ceuse (Final disease or condition resulting in death)	PERITONITI			ac or respiretory erre	st,	Approximate interval Between Onset and Deet			
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nding physician end use as the burial-transit n/Medical Examin	Cause (Disease or injury thet initieted events resulting in death) Last	C	r es e consequence of							
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been signed by ahould be detac					24a. Wes er	n autopsy 2	Probably 4 Unk      Ware autopsy findirevailable prior to completion of cause			
cartificate hes been si rector, page 2 should Be Completed	8 7				1 Ye	s 2 No	of death?			
Se ctor	25. Was case referred to medical exeminer?	Hospitel:		Other	eeth (Check only on					
After this funeral di	Yes 2 No  27. Nanner of Death 14 Natural 5 Pending 2 Accident Investigation	28a. Dete of injury (Month, Dey Year)	OOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No	ry et ck?  28d. Describe how injury occurred ck?						
within 24 hours also beart.  To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route In City or Town, State)									
the Funer pletely fill edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examine end menner stated.								
To the	29b. Signature and title of certifier	melfile	W) 2	9c. License number O.C.M.E		ed. Dete signed (A anuary 05				
	30. Neme and address of person who Margarita Korel			n Street, Ba	ltimore !	Marvland	21201			
					THE RESERVE AND ADDRESS OF THE PARTY OF THE					

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amend # 23a. Per Phys. PGC 1-5-00 cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December Alphonso R. Williams, Jr. 1999 4:35 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs. Director 577 68 5881 48 May 30,1951 Washington DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or hame 23s or 28s-f ahow the Medical Examiner must be notified at M Yes 2 No Director Maryland Prince George's Hillcrest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3392 Curtis Drive #202 20746 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status o filed within 72 hours after if Hyglene. other then "natural", or the 1 ☐ Yes 2 ☐ tNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 Black 1 ☐ Yes 3 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Plasterer Government permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if Itam 27 is marked other only Injury or other traumatic aventional. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Anna Jones Alphonso R. Williams, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alphonso R. Williams, Sr./father 3392 Curtis Dr. #202 Hillcrest Heights, MD 20746 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other plece)
Washington National Cem 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 12 - 29Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee Sisscort on MARSHALL'S FI

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. 4308 Suitland Road Suitland, MD Approximete Intervel Between Onset and Deeth ASPIRATION PNEUMONIA Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner 2 Days that the death certificate be executed physician and s the buriat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 d be datacl 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE Heart failure Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? END STAGE RENAL FAILURE s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: Within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Anpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Matural 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide odical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of continu D 50653 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN.C. SURANA CHURCH TON 20751 ROAD DEALE 31. Date filed (Month, Day, Year) 32. Registrar'a Signeture

**DHMH 16 Rev 6/95** 

Registrar

JAN 0 5 2000

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Plea	Ise Type or	Print In Black I of Maryland / De	ndelible ini	K. Assure Al	lopies A	re Legib	ie.
9a.& 19b.Per FH	I PGC 1-6-	00 cr C	ertificate of	Death	Rei	3. No. 9 9	42751
1. Decedent's Neme (First, Middle	le, Last)				2. Date of Death Month	Dey - 99	3. Time of Death
Louis		Wells			12-	-31-99	7:20am
4e Facility Neme (If not institution SOUTHERN MAR				4b. City, Town, or Lo		4c. County of PRINC	Death E GEORGE'S
5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Yea		B. Date of Birth	(oar)	9. Birthplace (State or Foreign

**Funeral** Director

**Physician** 

/Medical **Examiner** 

Directo

Funeral

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at another. Baltimore, Maryland 21215-0020 δ Completed Be **Physician** /Medical Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760, Physician/Medical 980 P.O. Division of Vital Records, Completed by page 2 s or Attending Physician: Be Certification: To this funeral Affer To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. Medical 29a, Certifier

Amend #'s 1 100 M 2□ F 149-26-2837 64 3-27-1935 New Jersey Usuel Residence of Decedent 10b. County 10c. City, Town or Location Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 4306 Will Street U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Meritei Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer 11th 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) John Lee Wells Susie Sibert 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wells /Son Brother 4306 Wills Street, Capitol Heights, Maryland 20743 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 01/08 20c. Location - City or Town, Stata 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Brentwood, Maryland J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23e. Part 1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lina. Immediate Ceuse (Finel disaase or condition resulting in daath) RESPIRATORY FAILURE Due to (or as a consequence of): BRONCHO GERIC FMONIONA Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): CHRUMIC DESTRUCTUE

PULMONANT DI SCA Due to (or as e consequence of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. DEPENDENT DIABETED HOW UASCUURT 切ららいて PERIPHERAL FINISHAGOSIHOE

24a. Was an autopsy performed? 1 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Approximete Interval Between Onset and Deeth

10d. Inside City Limits 1 XYes 2 □ No

**Black** 

Private

25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ♣ No 28a. Deta of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

> 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier ch su cum in

D34498

29c. License number

29d. Date signed (Month, Day, Year) 2, 2000 JAN

23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

JE MUNGST UN BRUNC

TOO OLD BRANCH AUE. STE B-102 20135 CUINTUN, MD.

31. Date filed (Month, Dey, Year) JAN 0 5 2000

(Check only one)

32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Birthplece (State or Foreign Country) Date of Birth (Month, Dey, Year) Min. Days Hours 180 M 2□ F 233-26-8764 Usuei Residence of Decedent 78 May 10,1921 Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince Georges College Park 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 3533 Marlbrough Way 20740 United States 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 1944 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Heavy Equipment Operator Contruction 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Walker Gertrude Price 19e. Informent's Name/Reietlonship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pearl L. Kager B533 Marlbrough Way, College Park, Md 20740 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1/7/2000 Brentwood, Md Fort Lincoln 21. Signature of Funeral Service Licansee 22. Neme end Address of Fecility Fort Lincoln Funeral Home 3401 Bladensburg Road, Brentwood, Md 20722 23e. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) Due to (or es e consequença of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequença of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 000 1 Yes 26. Plece of Deeth (Check only one)

**Physician** /Medical Examiner

physician

**Physiclan** /Medical

Examiner

10a. State

**Funeral** 

Director

ral', or items 23a or 28a-f shov Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s any injury or other traumatic event, it a frac

Baltimore, Maryland 21215-0020

Directo

Funeral

þ

Completed

Be P

the Maryland show

> es the buriel-trensit signed by the ettending to be deteched for use page 2 should funeral director,

or Attending Physician: The lew requires that the death certificate be executed

certificate

After this

Box 68760.

Division of Vital Records, P.O.

Physician/Medical Examiner Completed by Be Certification: To

To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A filled in by the

State Registrar

Medical

25. Wes case referred to medical examiner? Hospital: 1 ☐ Yes 2 ☐ 08

Other: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury 28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner as steted.

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one)

2 | Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signeture and title of certifies

28a. Dete of Injury (Month, Dey Year)

29c. License number

29d. Dete signed (Month, Dey, Year) 2000

30. Name and address of pr led wause of deeth (Item 23e) (Type, Print)

2050 Wildwood Center, California, Md 20619 Boyd James

6 2000

27. Menner of Deeth

Maturel

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

5 Pending Investigation

6 Could not be determined

32. Registrer's Signature

28e. Plece of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify)

town to front

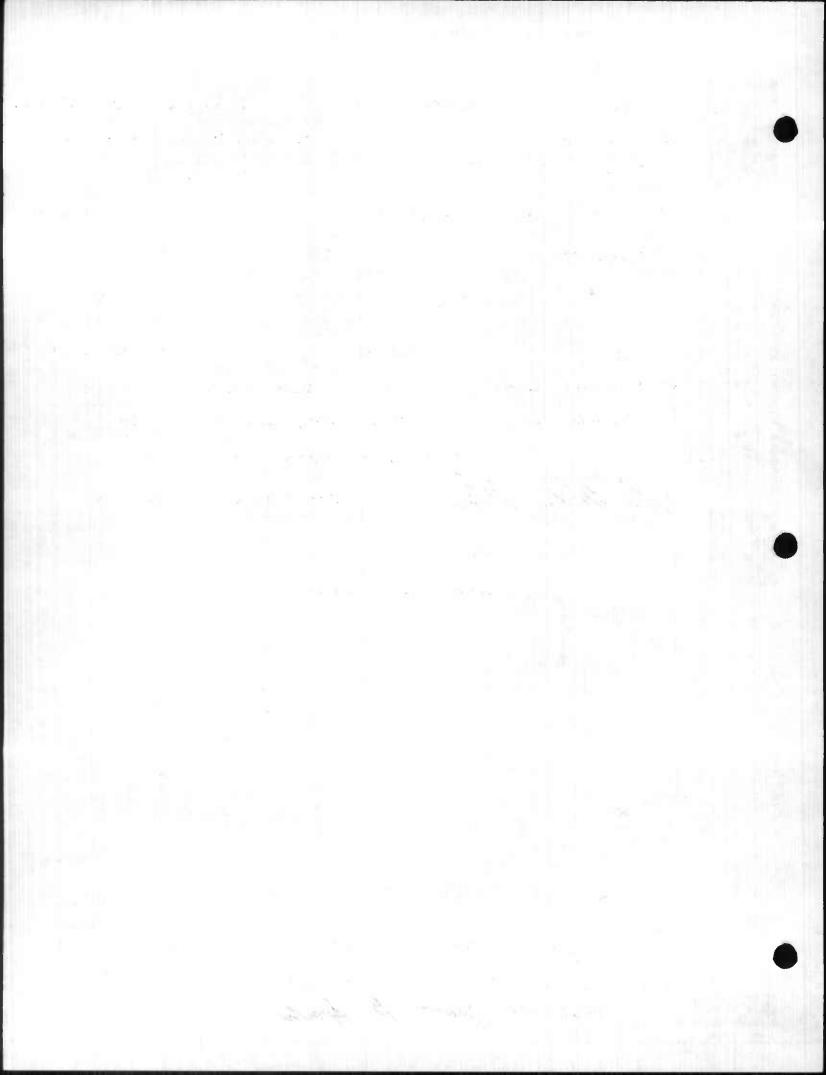
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180 0 0 2000

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42753

			C	ertifica	te of	Death		Reg. No.			
	1. Decedent's Name (First, Middle, Las	st)	-				2. Date of De		Van	3. Time of Death	
Physician /Medical	JAMES	WAS	SON				Decemb	er 27,	1999	12:45 p.m	
/Medical Examiner	4a Fecility Neme (If not institution, give	e street end number)				4b. City, Town, or	Location of Deal	h 4c. County	y of Death		
	531 James Avenue				Tracy's	Landing	g Anne Ar		undel		
Funeral		Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 H					8. Date of Bi	8. Date of Birth (Month, Dey, Year) 9. Birthp		elece (State or Foreign	
Director	577 26 9235	MM 20F 77	Yrs.				Aug. 2	29, 1922 P			
tygiene. ther than "naturel", or items 23a or 28a-1 show out, the Medical Examiner must be notified at	Usual Residence of Decedent  10a. State 10b. County		10d. inside								
tal hygiene, and the hygiene star or 28a-f show and the hydiene framinst mant be notified at event, the Medical Examinst mant be notified at Be Completed by Funeral Director	MD Anne Aru		City, Town or racy 's		ino			1 ☐ Yes			
oto		nder	racy 5					10g. Citizen of What Counfry?			
nings must be notified Puneral Director	10e. Street and Number			10f. Z	ip Code			itry?			
rai	531 James Aven				207			USA			
Line Line	11. Marital Status	12. Wes Decedenf Ever Armed Forces?	in U,S.	<ol><li>Was Deci If Yes, sp</li></ol>	edent of le ecify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ca - Americ ick, White,		
by F	1 Never Merried 2 Married	1 V Yes 2 No If Yes, Give 1 C	43-45	1 🗆 Yes	Yes 2 No Specify:			Specif	v: wh:	ite	
d b	3 Widowed 4 Divorced			1 1 1 1 1 1 1				405 101 4 - 4 9			
nt, the Medical	15. Decedent's Ed (Specify only highest gre		16a. De	cedent's Us	vai Occup	pation during most of wi d)	orking	16b. Kind of B	usiness/inc	Justry	
d E	Elementery/Secondary (0-12)	College (1-4or 5+)		ctrici		id)	commercial constructi				
5 0	12 17. Fether's Name (First, Middle, Last)				- (11	19 Mother's No	eme (First, Middle			CONSTRUCT	
To Be											
To	William Paul	Wasson		Agnes Sharp Balentine							
2 6	19a. Informant's Name/Relationship (			_	ng Address (Street end Number or Rural Route Number, City or Town, State, Zip Cod Old Landing Rd., Accokeek, MD 20607						
her to	Linda W. Savage					ling Kd.,				0044	
8	20a. Method of Disposition  1 Buriai 2 Cremation 3 D	Removal from State	b. Place of Dis cemetery, o	remetory or	other ple		Date	20c. Location			
5	4 ☐ Donation 5 ☐ Other (Specific	TA A	letropo.	litan	Crem	natory	12-28-9	Alexa	ındria	a, VA	
E S	21. Signature of Funeral Service Litter	B9 , 00		22. Name a	and Addre	ess of Facility					
1 1 2	11. Mrs.	1 19her		Rausc	h Fu	neral Ho	ome. Owi	nes. MD	2073	36	
	23a. Part1. Enter the disease, or com-	plications that caused the	death. Do not					-		Approximate	
ysician	shock, or heart feilure. List only	one cause on each line.							1	interval Between Onset and Death	
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niner	disease or condition resulting in death)	ä									
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etached for us Physician	Part II. Other eignificant conditions of	ontributing to death but no	resulting In the	e underlying	cause gi	iven in Pert I.	23b. Did	TO SHEET TO SHEET		o the cause of death?	
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2 2							040 11/0		T 24h W	ere autopsy findings	
should leted								s an autopsy ormed?	av	valiable prior to	
0 0									of	death?	
Com							1 🗆	Yes 2000	10	☐ Yes 2☐ No	
rector, pa	25. Was case referred to medical					26. Piece of D	eeth (Check only	one)			
	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 🗆 🛭	OOA Ot	her: 4 Nursing	Home 5 Res	Idence 8 DOt	her (Specil	5/)	
	27. Menner of Death	28a. Date of Injury (Month, Dey Yea	28b. Time		28c. Inju	ny at	28d. Describe	how injury occu	rred		
atio	1 ► Neturel 5 □ Pending investigation		ir) injui	M		Yes 2 □ No					
led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b	200. Placa of Injury		streef, facto	ory, office		28f. Location	(Street end Num	ber or Run	al Route Number,	
e din	4 Homicide	building, etc. (S	ecify)				City or 10	wn, Stete)			
completely filled in Medical Cert	29a. Certifier 154 Certifying Ph	ysician: To the best of my	knowledge, de	ath occurre	d at the t	ime, date and place	ce, and due to the	cause(s) end m	nenner as s	stated.	
completely filled in by the Medical Certifical		niner: On the basis of examiner and manner stated.									
Me Me	29b. Signature and fitle of certifier			2	9c. Licen	se number		29d. Date sign	ed (Month,	Dey, Year)	
ŏ		Toucho ME	2		047	7610		Decembe	r 28	8 1999	
					- ()	31 3			- 20	, /	
1 VA	30. Name and address of person who					00177					
· V/T	David Tardio, M		e Frede	rick,	MD	20678					
State	31. Date filed (Month, Dey, Year)	32. Registraris S	ignature	4	1						



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42754

Physician /Medical Examiner uneral irector	219-56-2079	give street and numbrial Hospit  6. Sex 12M 2DF	al Age (In yrs. last	t birthday) • Yrs.	WALL  If Under 1 Yea Months Deys	Princ	e Fr	2. Data of Dee Month DECEMI cation of Death ederick 8. Dete of Birth (Month, Dee	BER 29	of Death Calve	
/Medical Examiner uneral irector	Calvert Memory Calvert Memory S. Social Security Number 219-56-2079 Usual Residence of Decedent 10a. State 10b. County Maryland Cal 10c. Street and Number 1890 Sollers V	eial Hospit	Age (In yrs. last	t birthday) • Yrs.	If Under 1 Yea	Princ	e Fr	ederick	4c. County	of Death Calve	ert
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-	Maryland Call 10e. Street and Number 1890 Sollers V 11. Marital Status		10c. City, T					July 29	year) 9. Birthpiaca (State Country) 1952 Maryland		
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a marked other humatic avent, To Be C	17. Fathar's Name <i>(First, Middle, i</i> Joseph	C.	Wall	18. Mother's Neme (F					Meiden Sumen	King	
traumati T	19a. Informant's Name/Relations Vera Johnson/Si				g Address (Stree			y, MD 2		State, Zip	Code)
	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. Plec	e of Dispos etery, crem	sition (Neme of netory or other pl Church C	ece)	T	Date	20c. Location		
any injury or	4 Donation 5 Other (St. 21. Signature of Funeral Service 1	icensee	BLOW	22.	Name and Add	ress of Facili	ty Sew	ell Fun	Port Republic, MD eral Home e Frederick, MD 20678		
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	29e. Certifier 12 Certifying (Check only one) 2 Medical E	Physician: To the be examiner: On the basis	s of examination	dge, death and/or inv	occurred at the estigation, in my	tima, date ar opinion, dec	nd place, oth occurr	and due to the cred at the time, c	ause(s) and m late and placa,	anner as s and due to	ated. othe cause(s)
To the complete	29b. Signature and title of certifies	P. Si Ve	ans		29c. Lice	rse number			29d. Date signe	7- 7	Dey, Year)
3	30. Name and address of person v			Ba) (Type, F		RICK	MD	2067	8		

								C	ertificat	e of	Death	,	Reg. No.	4 6	. / 0	J
	Ohusisian		Decedent's Nam									2. Dete of D	eath	Year	1	ne of Death
	Physician /Medical		Anne La		-							Decemb	-	L999		11:30A
	Examiner	48	48 Fecility Neme (If not Institution, give street end number) 5911 John Adams Drive								Cemple H		th 4c. Count		cge'	s Co.
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	/lend		a. State	10c. City, Town or Location									de City Limits			
	Mer and Sa-f ah		MD			Temple Hills									Yes XX No	
	s 23s or 20 runt be no	10	10e. Street and Number 5911 John Adams Dri				rive			Code 20	748		10g. Citizen of Whet Country? United States			
5-0020 72 hours effer death with the Meryland natural; or flarms 23a or 28a-f show nicel Exerciting must be included at each of Furneral Director	11	. Maritel Status  1 Never Marr  3 Widowed		nried	. Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	ŽQXNo ∕e	U,S.	13. Was Deced If Yes, spec 1 ☐ Yes	SpecIfy Yes or N erto Rican, etc.)	14. Reca - American Indian, Black, White, etc.  Specify: White			n,			
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-	other true	-	Arthur F		ıg (nı	DODAMI	20b. Plece of Disposition (Name of					Date	20c. Location			
Baltimore	Peges net of int: If its	20a. Method of Disposition  1 Burial 2 Cremation 3 Removel from State  4 Donation 5 Other (Specify)  20b. Plece of Disposition (Name of cametery, cremetory or other pleca)  Lee Crematory Jan 3, 2000  Clinton, Ma										, Mar	ylan	id		
Balt	permit. Pege Department of Important: If any Injury or once.	21	21. Slorature of Funeral Home, Inc 6633 ( Alexandria Ferry Road, Clinton, Maryland 2)													
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	Physician /Medicai	In	shock, or hea	(Final	st only one	0	rolla		^	xt	ng, such es cardi	ao or respiratory	arrest,		Interve	l Between end Deeth
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x 68760,	certificate be executed nding physician and use as the bunal-transit		equentially list co any, leeding to In luse. Enter Unde ause (Diseese or et initieted event: sulting in death)	5	c	Po	Due to	or as a cor	nsequence of):	2	Verg	<i>y</i> ,				
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Records,	been si should											24a. Wa	s an eutopsy formed?	ev	ailable p	psy findings prior to n of cause
RE	The law											1	Yes 2 No	10	∃Yes	2 No
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ion of		1 Yes No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DO						28c. Injury at Work? 28d. Describe how Injury occurred					γ)			
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	(1)	30	Name and adde	100	on who com	pleted offis	e of deeth (II	tem 23a) (T	P. M	D	5226	dau	es Au	P.F.	7/0	X

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 4 2000

32. Registrar's Signature B. Loans

22311

NOAD SEELS THE PRESENT

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month Day Year 29, 1999 2:45 A.M. Woodrow Wilson Adkins Dec. 4e Fecility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Salisbury Wicomico 27490 Little Lane if Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours Yrs 83 1-15-1916 214-32-2352 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yes X No Salisbury Wicomico 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? USA 21801 27490 Little Lane 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Etementary/Secondary (0-12) College (1-4or 5+) Highway Dept. State Road Foreman 17 Father's Name (First Middle Lest) 18. Mothar's Name (First, Middle, Maidan Sumama) Florence Nicholson Adkins Charles Adkins 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Salisbury, Md. 21801 Blanche E. Adkins, Wife 27490 Little Lane, 20b. Place of Disposition (Nama of camatary, cramatory or other pleca) 20c Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 12-31-99 Mardela Springs, Md. Riverton Cemetery 4 Donation 5 Other (Specify) 22 Name end Address of Facility 21 Signature of Funeral Service Licensee Short Funeral Home, Inc. 23e. Pert1. Enter the disease, or complications that caused the thrath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 13 E. Grove St. Delmar, De. 19940 Approximata Interval Between Onsat and Death C.F.> congestive Heart Feviluir Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consaquance of): Sterros 5 Aon2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of depth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? H. Bluck. 24a. Was an autopsy 1 Yas 2 No 1 Yes PONO 26. Place of Death (Check only ona)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Med cal Examinar must be notified at

al Hygiena.

. Pages 1 and 2 should be file ment of Health and Mental H-lant: If item 27 is marked oth jury or other traumetic even

permit. Page Department of Important: If any injury or

the Maryland

with

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Box 68760.

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Division of Vital Records,

Examiner physician and s the burial-transit Physician/Medical 88 USB by Completed director Be 2 Certification:

the death certificate be executed ed by the a signed by t certificata has b lirector, page 2 s Attanding Physician: this funeral After I or Attendin after death. Director: Aft filled in 24 hours a Hospital

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death Naturat 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be datarmined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

and manner steted.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

Other: 4 Nursing Home 6 Hesidance 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and figle of certifier

29a, Certifier

29c. License number 1) 2536

1 Yes 2 No

29d. Date signed (Month, Day, Year) 12/29/99

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

614 Enstelm 31. Date filed (Month, Day, Year)

SHORKE

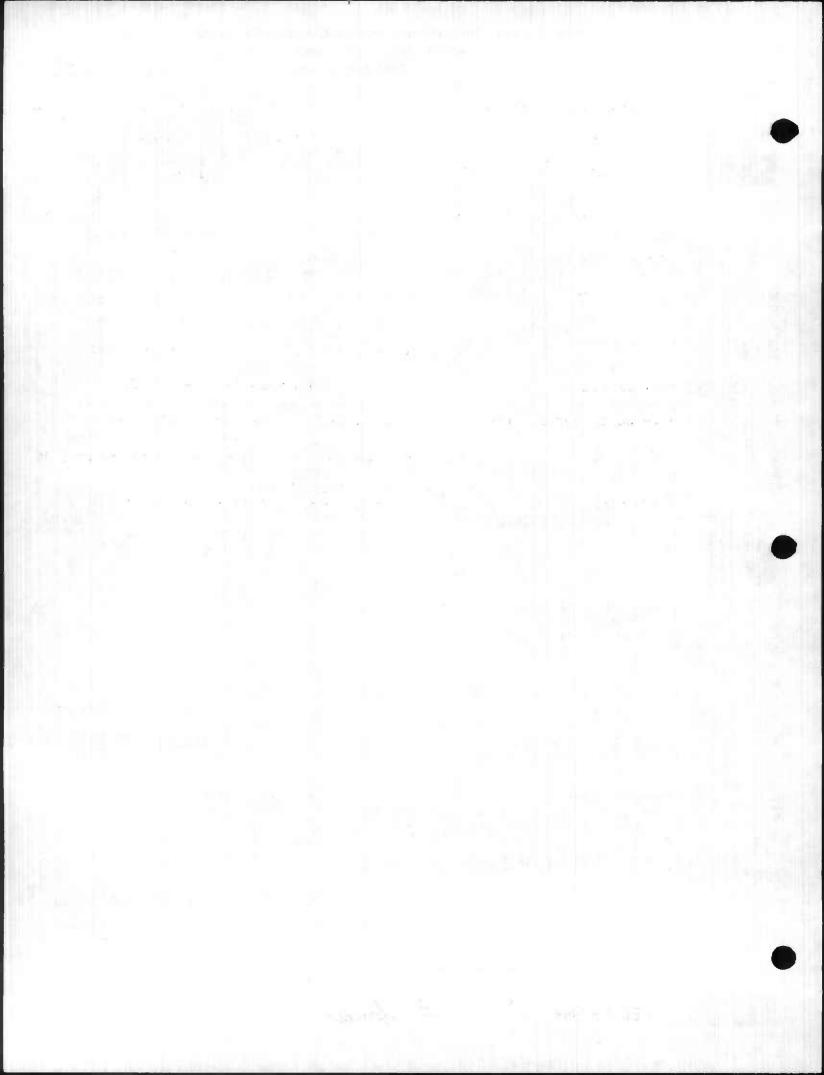
SALIBMY.

State Registrar

edical

82. Registrar's Signature DEC 2 9 1999

To the Hosp within 24 hor To the Fune completely fi



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 1715 Kristen Chester 22-99 12-/Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours Min. 56 1 M 2 F Months 7-2RU Maryland Director 0 0 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No 28a-f Directo Maryland Wicomico Salisbury 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? à Nerns 23s 704 Richmond Avenue 21801 U.S.A 12. Wes Decedent Evar in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 1 Yas 2 No If Yes, Give Yaar or Dates: 1 Never Merried 2 Merried 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black À 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 None None 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Jermaine Chester Leslie James 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jermaine Chester (Father) 704 Richmond Ave. Salisbury, Md. 21801 Department of Health Important: If Item 27 20b. Plece of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Dete 20c. Location - City or Town, Steta 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem.Garden/ Hebron, Md. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801 B. Stewart 23a. Part1. Enter the dispese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haer failure. List only one cause on sech line. Approximete Interval Between Onsat and Death **Physician** Prematur /Medical Immediate Cause (Final Zhour. disaasa or condition resulting In death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) P.O. Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown signed d be del Records, by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy parlormed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Hospital or Attending Physician: Be 25. Wes casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Inpatient edical Certification: To 1 Yes 20 No 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28d. Describa how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Division Neturel 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not ba 3 Suicide 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the bast of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of conifici D-33/82 79.WO 12/22/19.

State Registrar

S. GUPTA, morMD. 31. Data filed (Month, Day, Year) DEC 27 1999

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

-7548 )-MOTHER

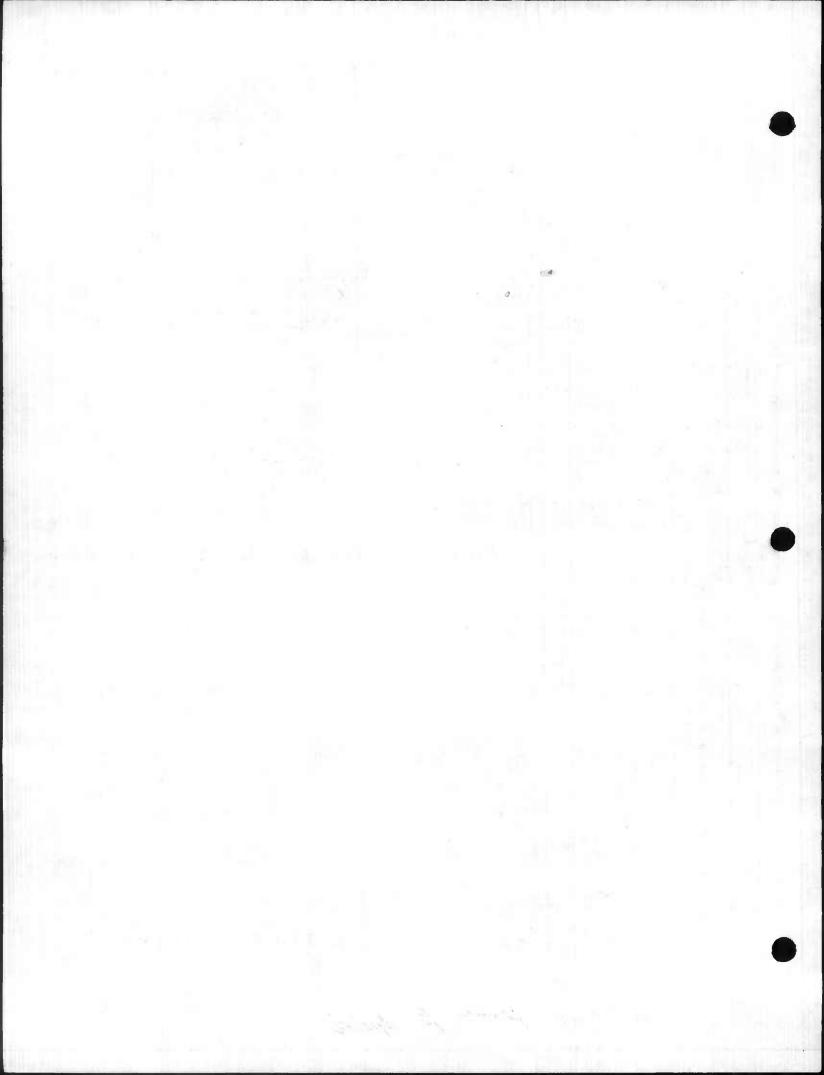
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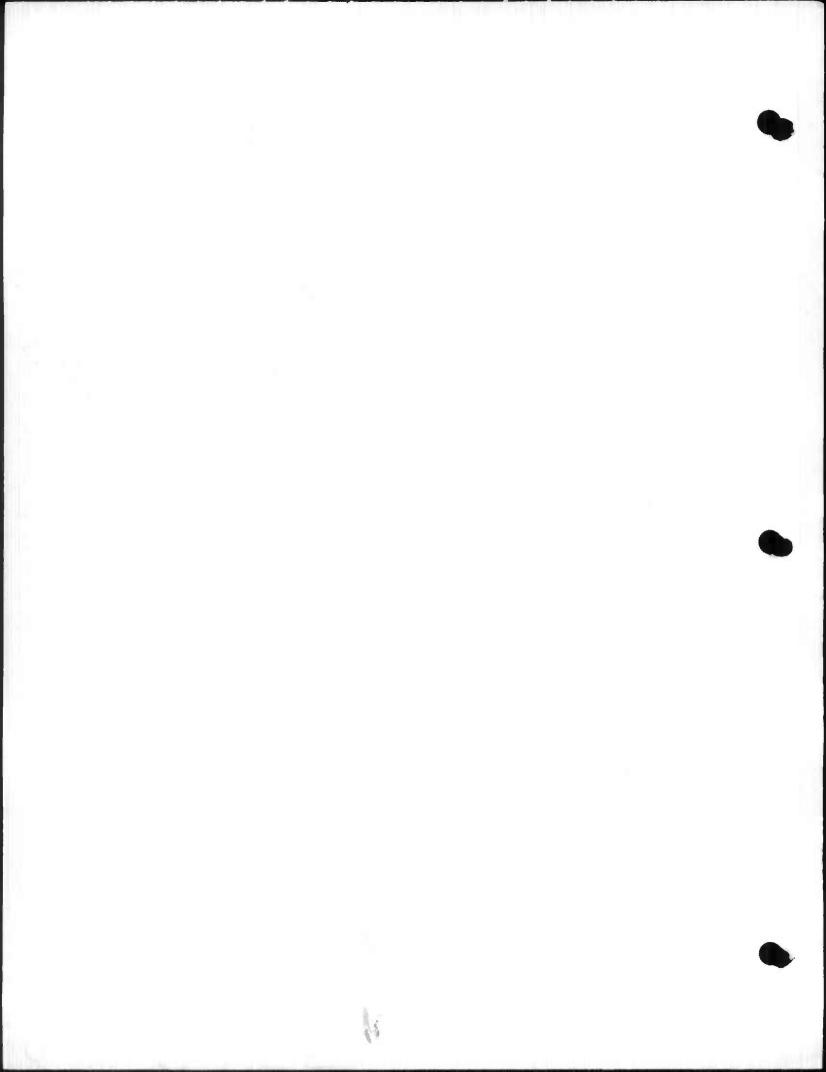
PENINSULA REGIONAL MED GTR, SALKBURY, MD.



DIVISION OF VITAL RECORDS, P.O. BOX 68760  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without the strength of the attending physician and completely flag in the strength of the attending physician and completely flag in the strength of the physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely flag in the strength of the physician. The pages 1, 2, 3 should be filled within 72 hours after death with the Strength of the physician.
--

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT (	OF DEA	H AND	MENTAL HYG	IENE	ככ	42/	00	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF CEAT	Н		3. TIME OF DE	ATH	
	CORA ELIZABETH (	CAVEY					DEC.	DAY 19	1999	9:55	Α м	
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 Y	EAR IF UND	ER 24 HRS.	7. DATE OF BIRTH	1	1//	IPLACE (State or	71	
	220-18-0332	1 M 2 XF 9	YRS.	MONTHS D	AYS HOURS	MIN.	Sept. 29	nr)	Count	ry)	· orangiri	
	9a. FACILITY NAME (If not institution, give str			96. CITY. TO	OWN OR LOCA	TION OF D			DUNTY OF C	yland		
DIRECTOR												
JE C	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR I	LOCATION					TY		
		Maryland Wicomico Salisbury  100. STREET AND NUMBER 109. CITIZEN										
FUNERAL	105 Coulbourn Dri		WHAT COUNTRY	,								
5	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 4 Divorced  12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2/2/(NO IF YES, GIVE WAR OR DATES  1 YES 2/2/(NO Specify: Section of Married II YES 2/2/(NO Specify: Section of No.)  1 YES 2/2/(NO Specify: Section of No.)										dlan,	
BY												
										White		
COMPLETED	15. DECEDENT'S EDUCI (Specify only highest grade of	ATION :ompleted)	(Give kind of a	work done duris	PATION ng most of wor	king	16b. KIND OF	BUSINESS/I	NDUSTRY			
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	•								
M	7th		seamstr	ress			Shirt	Facto	rv			
8	17. FATHER'S NAME (First, Middle, Last)				18. MO	THER'S NA	ME (First, Middle, Ma	iden Surname,	)			
BE	J. Frank Cutsail		,				3. Gue					
2	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or					
_	<u> Shirley Lambertson</u>	/daughter	8612 1	Whites	ville	RD -	Pittsvi	lle. N	4D 2	1850		
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove		PLACE AND DATE (	ther place!				LOCATION -				
	4 Donation 5 Other (Specify)	ISt.	Paul's	U.M.	Ch. C	emet	12/22 V	Venona	. Mar	vland		
	21, SIGNATURE OF UNERAL SERVICE LICE	MORE		22. NAI	WE AND ADDR	ESS OF FA	CILITY 1213	Jerse	v Roa	d - Sal	isbur	
	1 Attilia	MALI	11									
	23. PART I. Enter the diseases, or co	omplications that coused t	the death. Do n	not enter the	mode of d	MURJ	AL CHAPE	enderstory (	erreat	MD 218 Approxi		
	snock, or neert failure. L	lat only one ceuse on eac	ch' line.							Interval	Between	
	IMMEDIATE CAUSE (Finel disease or condition	marine	leal.	(	DIJA	.0	4 -11	2	1	Onset a	nd Death	
	resulting in death)	PHE TO OR AS A S	STORES OF	nue (	1	10	rugui	par	ures	125	days	
_	_	Masseul DUE TO (OR AS A.	soc, E	recep	clas a	note	Basel	Gan	glin		l	
CERTIFICATION	Sequentially list conditions, "	DUE TO (OR AS A C						/				
'AT	If any, leeding to immediate cause. Enter UNDERLYING	,		,						İ		
Ĕ	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	7:						<del>-</del>		
E	resulting in death) LAST											
CE	0.											
AL	PART II. Other algolficent conditions	contributing to death but	not resulting I	in the under	rlying ceuse	given in	Part I. 24s. WAS	AN AUTOPS	Y 24b	WERE AUTOPSY		
200	Jeabelles Mi	ellers 14	pe 11.	air	cal			S 2 K NO		COMPLETION OF		
MEI	Fibrellation	. Simile	Deme	ntia	_			-		OF DEATH?	LNO	
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S D NO	UN D	CERTAI	v m l				,	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		. PLACE OF DEAT	TH (Check only								
Sic		HOSPITAL: 1   Inpatient 2   ER/Outpati	lent 3 DOA	OTHER:	Home 5 1	Pasidanas	6 Other (Specify)					
ΗY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 284	. INJURY AT	randerice	28d. DESCRIBE HO	OW INJURY O	CCURED			
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY	WORK?	□ NO						
ВУ	2 Accident Investigation 3 Suicide & Could and be	26s. PLACE OF INJURY -	- At home, farm, s				28f. LOCATION (Str	met and Numb	ser or Prival E	South Mumber		
	4 Homicide 6 Could not be	building, etc. (Specify	)				City or Town, S			iosto Nombel,		
Ш	29a. CERTIFIER											
MP	(Check only one) 2 MEDICAL EXAMINED	IAN: To the best of my knowled	ige, death occurre	d at the time,	data and plac	e, and due	to the cause(s) and	menner as si	lated.			
COMPLETED		On the beels of examination s	ing/or investigatio	n, in my opini	on, death occ	ured at the	fime, data and place	, and dua to	the cause(s	) and menner as	stated.	
ш	29b. SIGNATURE AND TITLE OF GERTIFIER	DAN DC	1		29c, LI6	CENSE NUN	MBER	29d. D/	ATE SIGNED	(Month, Day, Year	r)	
0 B	Julgorn M. B	ellow, he	d		$\mathcal{D}$	295	05	1	2-1	19-99		
1	30. NAME AND ADDRESS OF PERSON WHO											
	GREGORIO M. BEL	LOSO, M.D.;	5302 C	HINAT	BERRY	Y DR	., SALIS	BURY	MT. MT	2180	23	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE L	1								
- 10	DEC 2 2 1000	1	17	1								

DHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 AMENDED #26, 01-04-00, (per MD), SRR, TALBOT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** 28 RONALD COLLIER 1999 2356 Dec /Medical 4s Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Talbot The Memorial Hospital Eas ton If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month Day Year April 16, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Year) 10 M 20 F Days 391-34-3411 1937 Wisconsin 62 Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location works / 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Talbot McDaniel Directo 288-1 Ronald Collier Baltimore, Maryland 21215-0020 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ð flerre 23a 9072 New Rd. Funeral 21647 U.S.A. 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifal Status 12. Was Decedent Ever in U,S. Armed Forces?

1X Yes 2 No U.S.

If Yes, Give Black, White, etc. 1 ☐ Never Merried 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: White Specify: ğ 3X Widowed 4 □ Divorced Yeer or Detes: Coast Guard Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self Employed Marine Mechanic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Alfred Collier Idella Mav 19s. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) G. Rene Rishel Stepdaughter 901 #1 Riverview Terrace St. Michael, Md. 21663 important: If Item 27 any Injury or other tr 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 Burlal 2 Cremation 3 Removel from Stete Olivet Cemetery Dec. 31. 1999 4 ☐ Donetion 5 ☐ Other (Specify) St. Michaels, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Md. Kunsun 21663 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical e. Arteriosclerotic Cardiovascular Disease Examiner vears Due to (or es a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) physician s the burial Box 68760. Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown þ 500 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 /3 No 1 Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Schesidence 6 Other (Specify) Certification: To 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide filled in by 4 ☐ Homicide Hospital 29e. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated completely Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) vons 12/29/99 D06804 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

S. Washington St., Easton, MD 21601

219

2000 Registrer's Signature

David Allan Stout, M.D.

31. Dete filed (Month, Day,

# BALTIMORE, MARYLAND 21203-3146

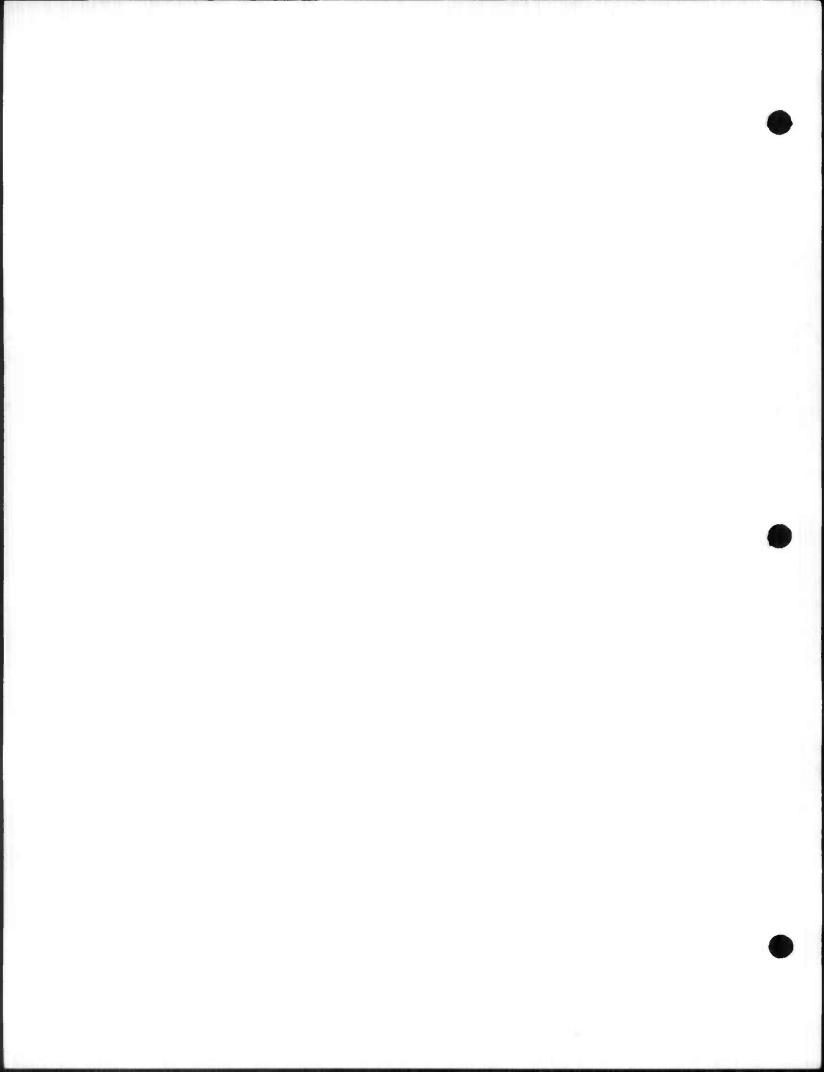
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a state death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTI	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First Middle, Last)	ee Davis		2. DATE OF DEATH	YEAR Q S S P M
	4. SOCIAL SECURITY NUMBER		F UNDER 1 YEAR	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
	225-04-6222	1 X M 2 F 39 YRS.	DAYS HOURS MIN.	Mar 8 1960	ASSAWOMAN VA
E	32/85 (Aste V)	(reet end number)	Westover		TY OF DEATH
5	RESIDENCE OF DECEDENT  100. STATE  100. COUNTY	Lan City	TOWN OR LOCATION	1000	10d. INSIDE CITY
DIRECTOR	MD Some	set We	staves		LIMITS?
RAL	100. STREET AND NUMBER	0.1	101. ZIP CODE	10g. CITIZ	EN OF WHAT COUNTRY?
FUNERAL	3 2685 (OSTER	12. WAS DECEDENT EYER IN U.S. ARMED	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexica		14. RACE — American Indien, Black, White, etc.
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	1 YES 2 NO Specify		Specify: Black
TED	15. DECEDENT'S EDU (Specify only highest grade	completed) (Give kind of wor	rk done during most of working	16b. KIND OF BUSINESS/INDI	USTRY
COMPLET	Elementery/Secondery (0-12)	College (1-4 or 5+)	1-1-1	Poultry Com	Danv
	17. FATHER'S NAME (First, Middle, Last)	)	16. MOTHER'S NA	ME (First, Middle, Majden Surname)	
8	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING A	DDRESS (Street and Number or Rural I	Route Number, City or Town, State Zio	Code)
유	Rose M. Davi	5 3268	5 Cosko Rd	Westoner MI	21871
	20e METHOD OF DISPOSITION  1 Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State 20b. PLACE OF DISPOSIT	TON (Name of cemetery, cremetory or	Reliabot	City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	22. NAME AND ADDRESS OF FA		ris-Neck
	D) ta	- (MOIOTI)	Morris Pineral	Joeville DE 1	9933
		complications that caused the death. Do not List only one cause on each line.	t anter the mode of dying, suc	h as cardiac or respiratory sm	est, Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	M-1. + L.	ymphone		Onset and Daath
	resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):	, pp. a.		syrs
NO	Sequentially list conditions,	b			
CAT	If sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	с			
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):			
	DART II Other elections and dise	a	the waterlyles source along to	Bart I are una su surmanu	Last Messes Messes Emission
CAL	PART II. Other significant conductor	is contributing to dastri out not resulting in	tha undarrying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDI					OF DEATH? 1 □ YES 2 □ NO
ä					
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO		26. PLACE OF DEATH (Ch OTHER:		
HX	27. MANNEB OF DEATH	26e. DATE OF INJURY 26b. TIME	OF 28c. INJURY AT	28d. DESCRIBE HOW INJURY OCC	CURED
ВУ Р	1 Natural 6 Pending 2 Accident Investigation	(Month, Day, Yeer) INJUI	M 1 YES 2 NO		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, farm, atr building, etc. (Specify)	set, factory, office	261. LOCATION (Street end Number City or Town, Stete)	or Rurel Route Number,
LET	290. CERTIFIER CERTIFYING PHYS	IICIAN: To the best of my knowledge, death occurred	at the time, date end place, end due	to the cause(e) end manner ee stat	ed.
COMPLETED	Corrock offing a	ER: On the basis of examination end/or investigation,			
BE	29b. SHUMAYURE AME TITLE OF CERTIFIE	"Clark"	29c, LICENSE NU	MBER 29d. DATE	E SIGNED (Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, F	Cripi) Cd Cd	/ WIA	2/66/
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	107. 001/3	7,100	21801
	DETER 2 0 1999	32. REGISTRAR'S SIGNATURE	2. 1. 1	$\cup$	



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month Dev **Physician GLADYS** ANN FOSTER DECEMBER 22, 1999 6522 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 6. Sex If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months 1 M 2 F Director 217-10-2225 84 April 12,1915 Virginia Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yas 2X No Maryland Salisbury Directo Wicomico 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 6139 Florence Ave. 21801 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Merital Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Presser Shirt Factory 6 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H lant: If Nem 27 is marked off jury or other traumatic even Be Harry Baker Mary Frances Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bertha Gordy/Sister 501 Madison St., Salisbury, MD 21804 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 12/27/99 Hebron, MD 22. Name end Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licenses 23a. Peht 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Intervel Between Onset end Death **Physician** · Carebro-viscular recordent / Stroke Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner anding physician and use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted eventa resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be del ò 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate has 1 Yes 1 Yes 2 No of Vital Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 10 1 mpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Swatural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 36783 ss of person who completed cause of death (Item 23a) (Type, Print) Princ Saissums b thet toh 32/Registrer's Signeture 31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

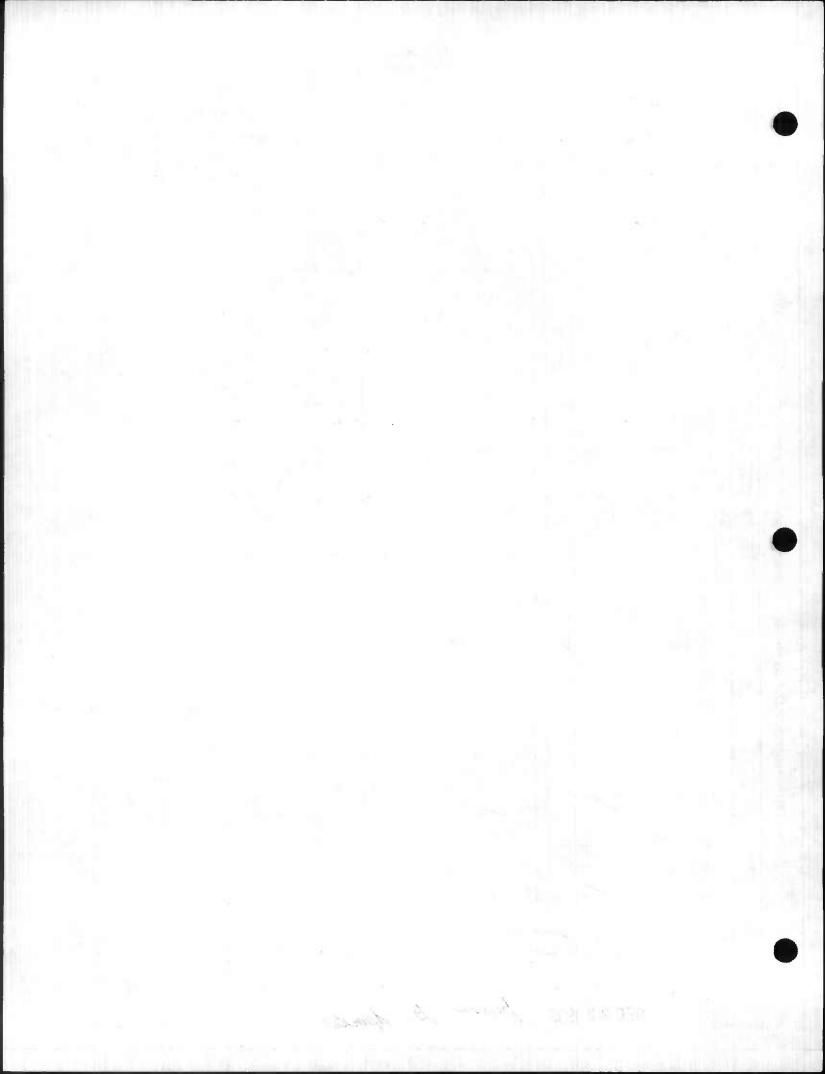
State

Registrar

DEC 23 1999

217-10-2225

GLADUS



# Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** December JACKIE LYNN GRIFFIN 0710 1999 16 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 217-52-2459 50 June 4,1949 Maryland Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits Maryland Wicomico Salisbury 1 ☐ Yes 2 DXNo Director 28e-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? b 4775 Airport Rd. 21804 USA Norna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) 12 Homemaker Domestic 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 Important: If Item 27 is marked of any Injury or other traumatic eve Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Oscar Lee Griffin Jr./Husband 4775 Airport Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/16/99 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Ligensee 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Examiner 0515 sician and burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial of Vital Records, P.O. Box 68760, DO nathemna Physician/Medical Due to (or as a consequence of): 200 USB signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 should After this certificate has 1 Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA uneral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Division 5 Pending investigation 24 hours after death.

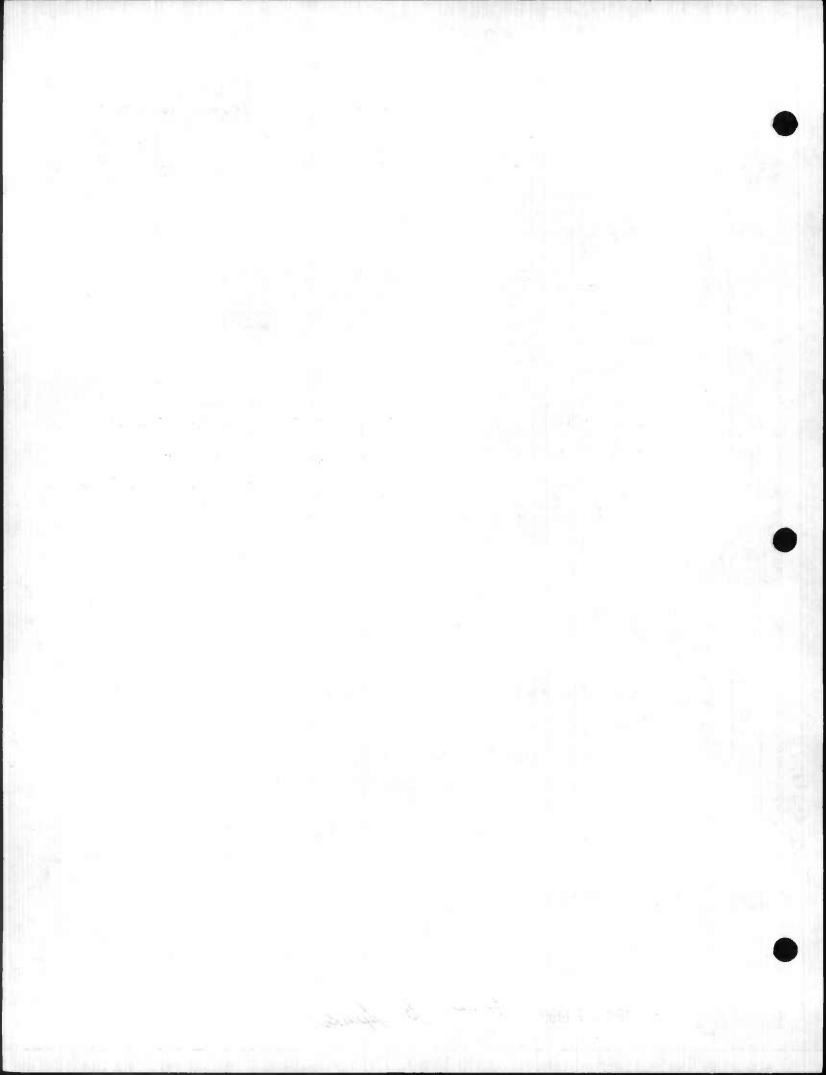
Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 9 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Day, Year) A. DAVIS MO 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Bishabe 3 DAVIS 31. Date filed (Month, Dey, Year) 32. Pegistrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

DEC 17 1999



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #20b, 01-04-00(per FD), SRR, Talbot Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Day Month Year **Physician** HATTIE J. GRANBY 1516 1999 Dec 27 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton If Under 24 Hrs Talbot If Under 1 Yaes 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Hours 1 M 2 XF Months Director 213-22-8449 98 March 15. 1901 Maryland Usual Rasidance of Decedant the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yas 2 📉 No Director Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerna 23a U.S.A.

14. Race - American Indian, 205 Dodson Ave. Funeral 2166312. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No
If Yas, Giva
Yeer or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seafood Domestic Seafood Worker 18. Mothar's Nema (First, Middla, Meiden Surnema) 17. Father's Nama (First, Middle, Last) Ith and Mentel H Be Pages 1 and 2 should be Franklin Clark Cornelia Bailey 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health at: If Nem 27 le Bernice Butler Daughter P.O. Box 525 St. Michaels, Maryland 21663 20b. Plece of Disposition (Nama of crematory or other place)

Cemetery Ja 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removel from Stete
4 Donation 5 Other (Specify) Department of Important: If any Injury or once. Jan. 3, 2000 St. Michaels, Md. 21663 22. Nama and Addrass of Facility 21. Signetura of Funaral Sarvice Licenses Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 auson Hordie 23a. Part I. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel MINHTES disease or condition rasulting in death) Examine Examine physician and s the buriel-trans Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Couse (Disease or Injury DENDEN Box 68760. NSGLIN DE the death certificate be Physician/Medical that initiated avants rasulting in death) Last Dua to (or es e conseguence of): ORONAR 080 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 2 No 25. Was casa rafarred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 0 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 1 Netural or Attending 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident after death Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 4 ☐ Homicida To the Hospital o within 24 hours af To the Funerel Di completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai 29a. Certifier (Check only 29b. Signature and titla of 29c. License number 29d. Data signed (Month, Day, Year) MAKAS 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print) 508 ISLEWIL EASTON MAKAS 00 AUE E.

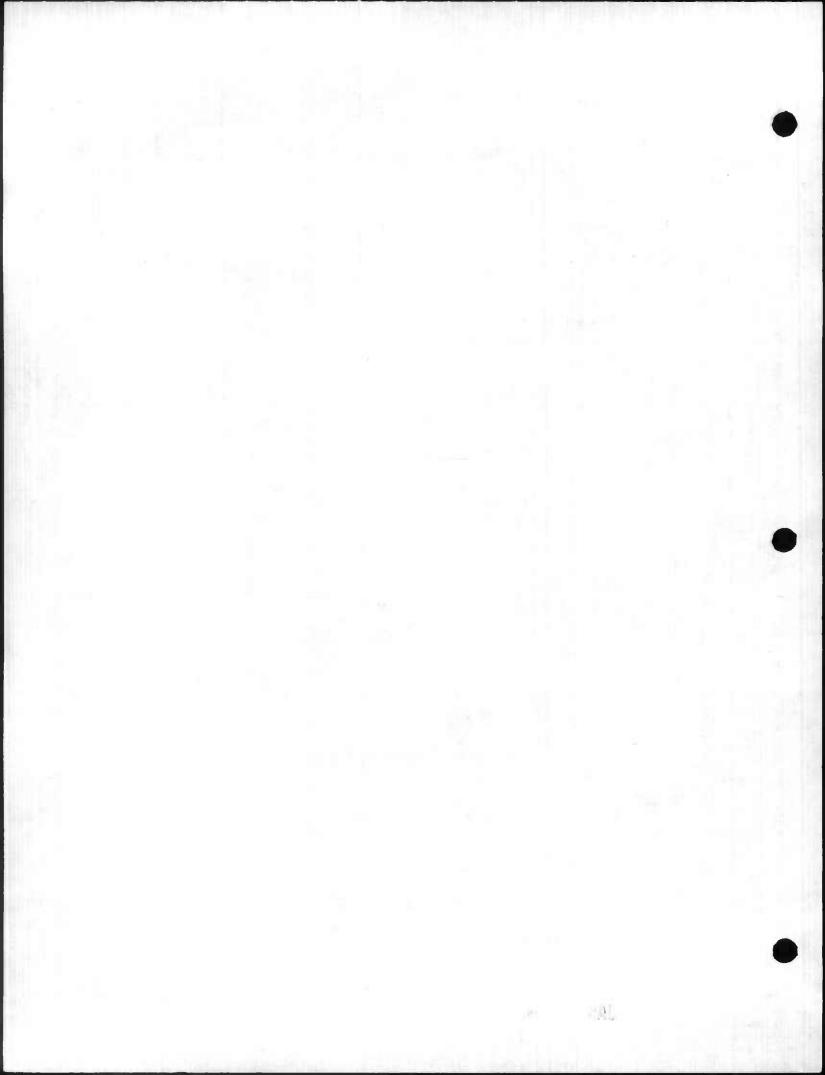
Registrar

State

31. Data filed (Month, Day, Year)

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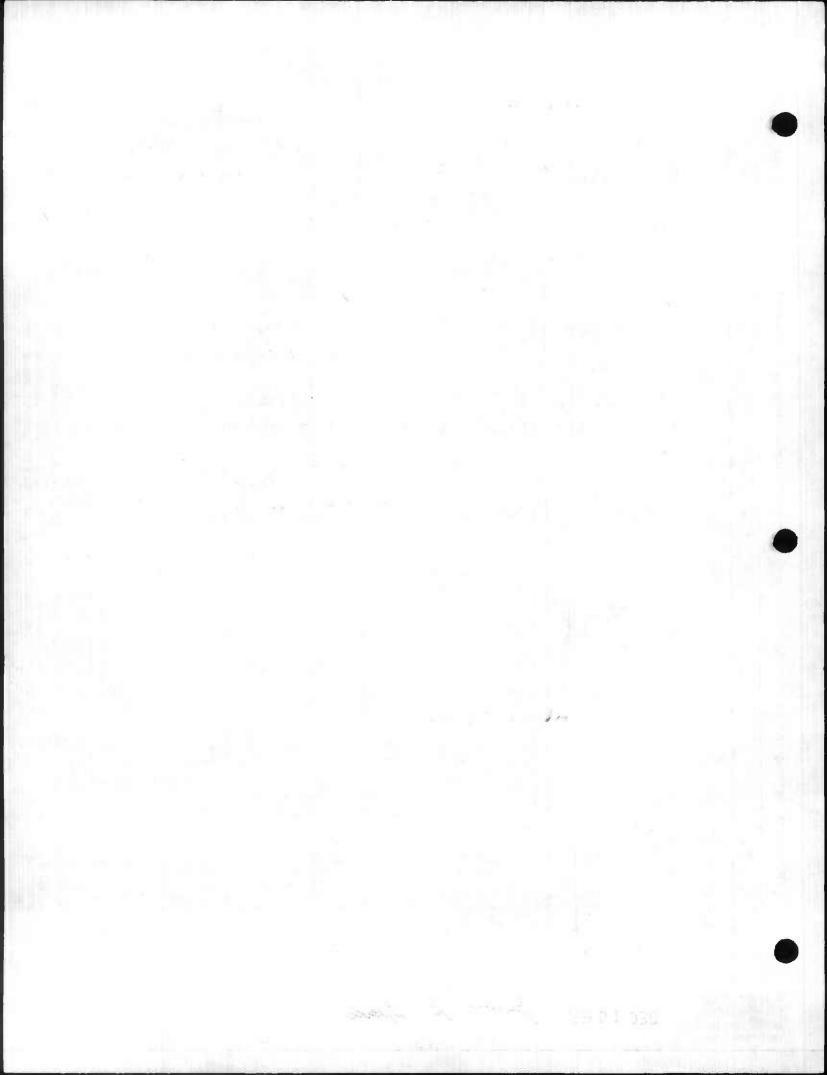
32. Registrer's Signeture



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Otis Hopkins 2:00 pm 10 99 12 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marcha Springs W ar If Under 24 Hrs. 8. Detend Birth (Month, Day, Year) School 11540 - ( 5. Social Security Number Id DINICO If Under 1 Year 9. Birthplace (State or Foreign Country)
DELAWARE 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 93 1 M 20 F Months 217-08-3408 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avant, the Medical Examinar must be notified at WICOMICO Md MARDEL 1 Yes 2 No SPRINGS Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene. Important: If Itam 27 Is marked other than "natural", or Nema 23a or 2 any Injury or other treumatic event, the Medical Exemples man health. Schoo 11540 Kd. 21837 SA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 250 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION ENVIROMENTAL SERVICES 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HOPKINS GOSLEE LEONARD MARTHA HOPKINS 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PATRICIA Daughter HEBRON, MARYLAND WINDER POB 401 21830 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremation 3 ☐ Removef from Stete 12/18/99 ZION Church CEMETARY SharpTONN, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility BENNIE SMITH FUNERAL HOME 21. Signature of Auneral Service Licensee 917-W. ISABELLE ST. SALISBURY MD. 21801 23a. Put I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ASVD HIGH Examiner Due to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Diobito, Atobe meri Distors. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No cartificata or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 27. Manner of Death
1 ☑ Naturat
2 ☐ Accident 28d: Describe how injury occurred edical Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-15-59 DRGGIZ 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 105 Par BILL M. S. Crouch Solisbung MO 7.401 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State DEC 16 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

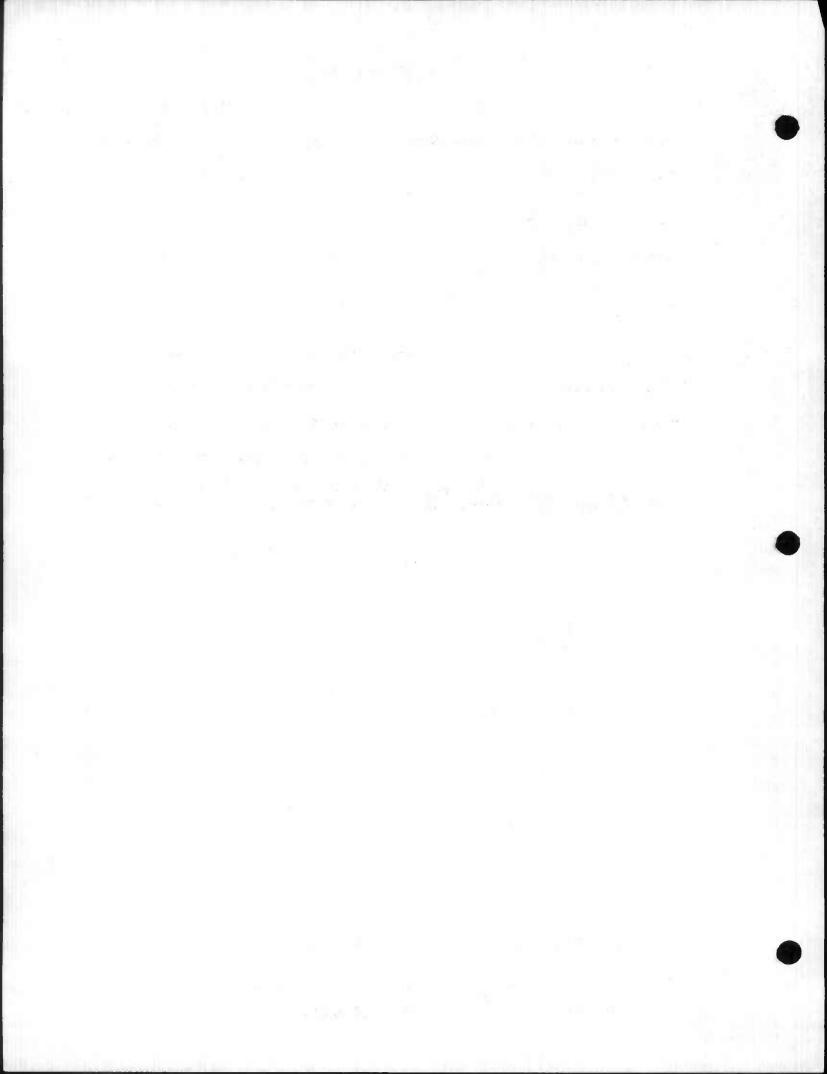
State of Maryland / Department of Health and Mental Hygien Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician VAUGHN **EMORY** HITCHENS DEC. 1999 9:20 A.M. /Medicai 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Months **X**OM 2□ F Director 222-09-7199 81 7-6-1918 Md. Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location ?7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 1 Yes 2 No Director Wicomico Delmar 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? 412 E. Walnut St. 21875 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status Bleck, White, efc. filed within 72 hours after 1X Yes 2 No If Yes, Give W Yeer or Dates: 1 ☐ Never Married > Married altimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: WWII Specify: by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Laundry Service Technician 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 end 2 should be Department of Health end Mental Important: If item 27 is marked or Arthur Hitchens Mary Wilson Hitchens 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Vonette Breeden, Daughter 412 E. Walnut St., Delmar, Md. 21875 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Date any injury or o 1 KBuriel 2 Cremetion 3 Removel from State St. Stephens Cem. Park 1-4-2000 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
Short Funeral Home, Inc. Pert1. Enter the disease, or complications that caused the death, shock, or heart feilure. List only one cause on each line. 23e. Pert J. Enter the disease, o 13 E. Grove St. Delmar, De. 19940-1114 Do not enter the mode of dylng, such es cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) DOES BLEED, NS GASTROINTESTINON Examiner Due to (or es e consequence of) Examiner attending physician and for use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Lest Due to (or es e consequence of): certificate be execu-Box 68760 Physician/Medicai Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown METASTATIC PNOSTATE CANEN Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior fo completion of ceuse of deeth? 24a. Wes an autopsy performed? Completed has 1□ Yes 2□No 1 ☐ Yes 2 No 25. Wes cese referred to medice! exeminer? Be 26. Piece of Deeth (Check only one) ie Hospital or Attending...., in 24 hours effer death. the Funeral Director: After this ce Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 27. Manner of Death 1 ☑Naturel 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M. D 13/00 all 5+IVA 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ROBERT ALLEN, M.D.-200 CIVIC AVENUE, SALISBURY, MD

32. Registrer's Signature

Registrar



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42766 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 1218 P. **DECEMBER 31, 1999** HAROLD HERSHEY 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) WORCHESTER ATLANTIC GENERAL HOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Day, If Under 1 Year 5. Social Security Number 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthdey) 1**X**M 2□ F Months Days NEW YORK CITY, Yrs. SEPT.30,1925 74 080-18-6208 NY Usual Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits X□ Yes 2□ No FRANKFORD SUSSEX DELAWARE 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 19945 U.S.A. 25 CLAMSHELL LANE 12. Was Decadent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER & SALESMAN AUTOMOBILE SALES 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) MAY HERSHEY VICTOR COHEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 CLAMSHELL LANE, FRANKFORD, DE 19945 HELENE S. HERSHEY 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LEWES, DELAWARE EASTERN SHORE CREMATORIUM01/03/99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses PARSELL FUNERAL HOMES & CREMATORIUM MOO 866 1449 KINGS HIGHWAY, LEWES, DE 19958 rart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting In death) Dye to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No

**Examiner** The law requires that the death certificate be executed pege 2 this cartificata director, 0

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

Physician/Medical

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Certification: To

Medical

3 ☐ Suicide

4 Homlcide

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

the Maryland

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Maryland 21215-0020

altimore,

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**Physician** /Medical

within 24 hours after To the Funeral Direc completely filled in b

Jershey, Harold

State Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only one)

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Borodulin 1 Choles

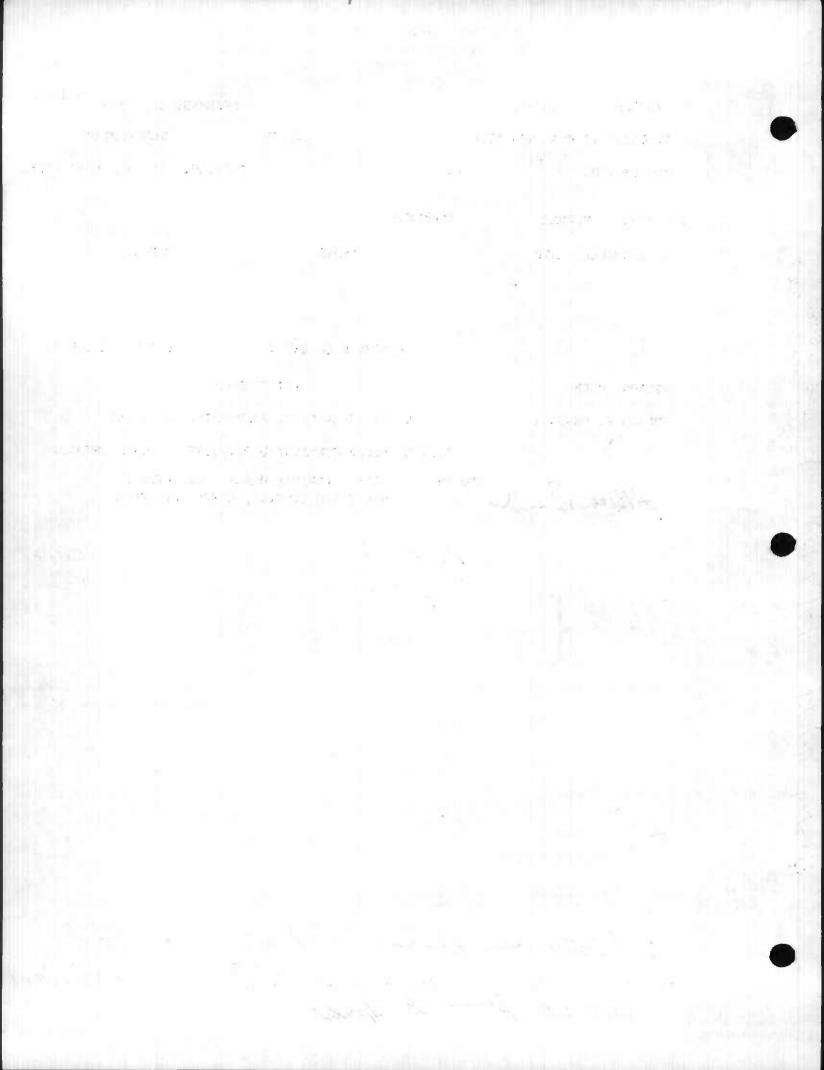
0 Ocean Highway

31. Date filed (Month, Day, Year) JAN 0 3 2000

32 Registrar's Signature

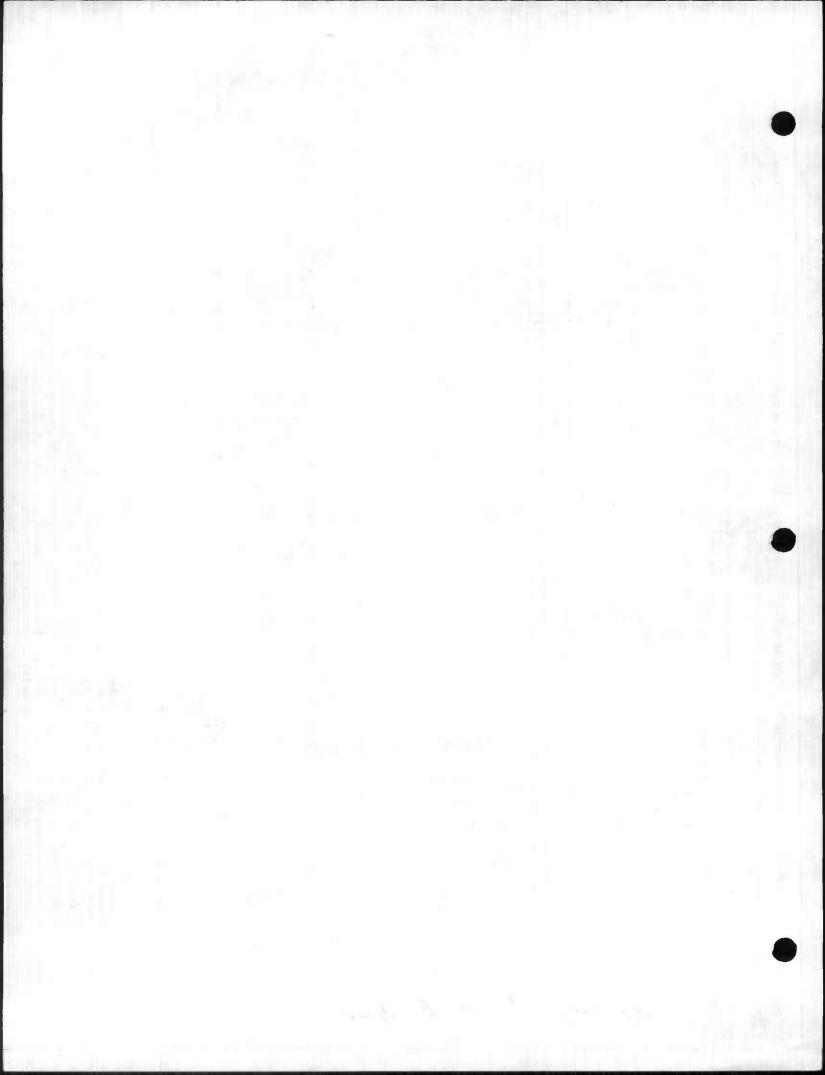
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	21			22. Name	and Addres	7	P- (1)	JEWIT AN	Dalu				
à de	21. Signature of meral Service Licensee  22. Name and Address of Facility  (BRNNIR 5mdh 7/4)  (G17 (A) 55 t TS shells 5t 5M shells												
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** HASTINGS KENDALL WALTER December 21st 1999 06:20 a.m. /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Wicomico Nursing Home Sallsbury Wicomico If Under 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign **Funeral** Days Months 18 M 2□ F Hours Country) MARYLAND 217-10-3939 Director SEPT. 13,1906 Usual Rasidanca of Dacedant 10a. Stata 10c. City. Town or Location 10b. County 10d Inside City Limits 1 Tyas 2 No Director MARYLAND WICOMICO SALISBURY 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code U.S.A. 21804 1502 LILAC DR. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcas?

1 Yas 2 No
If Yas, Giva Black, Whita, etc. 1 ☐ Nevar Married 2 ☐ Married 1□ Yes 2₺ No Specify: Specify: þ If Yas, Giva Yaar or Datas: WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) CARPENTER SELF-EMPLOYED 18 Mothar's Nama /First Middle Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be MONITOR WESLEY HANDY HASTINGS MARY LUCY ADAMS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) JOHN H. WILLIAMS - GRANDSON 128 E. MAIN ST. SALISBURY, MD 21801 20b. Place of Disposition (Nama of cematary, crematory or other p 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata SPRINGHILL MEMORY GARDEN\$ 12/24/99 HEBRON, MARYLAND 4 Donation 5 Othar (Specify) 22 Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensea 705 E. MAIN ST. CFSP BOUNDS FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SALISBURY, MD 21804 Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final mos disaasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 42 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1.80 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, atreet, factory, office building, atc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifiar Medical (Check only one) 29b. Signature and titla of certifiar 29c. License number 29d. Data aigned (Month, Day, Year)

State Registrar

2

31. Data filed (Month, Day, Year) DEC 2 2 1999

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DRIVE, SALISBURY, MD 21801 Registrar's Signature

50. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

29a-f show

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r than "natural", or liar the Medical Examiner

Hygiens.

mportant: If Item 27 is

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altimore, Maryland 21215-0020

Pages 1 and 2 should be Health and Mental

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital or Attending Physician:

this funeral

After

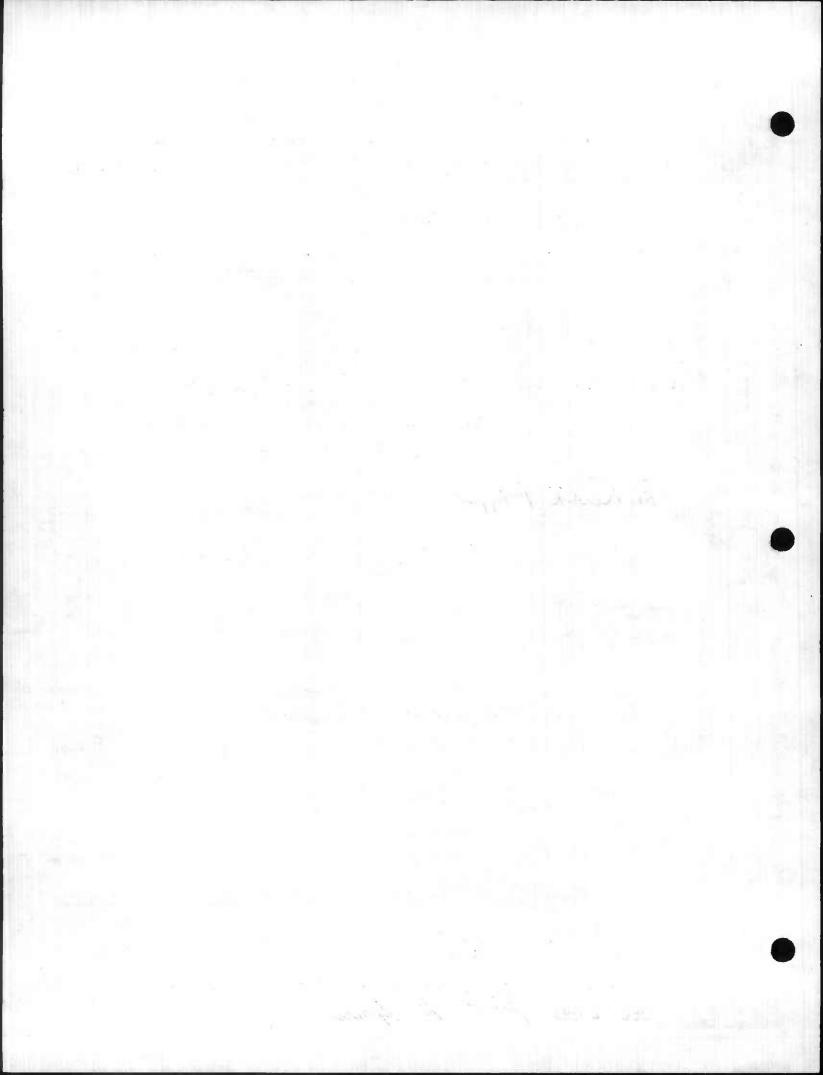
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To the Funeral Director: After completely filled in by the fun

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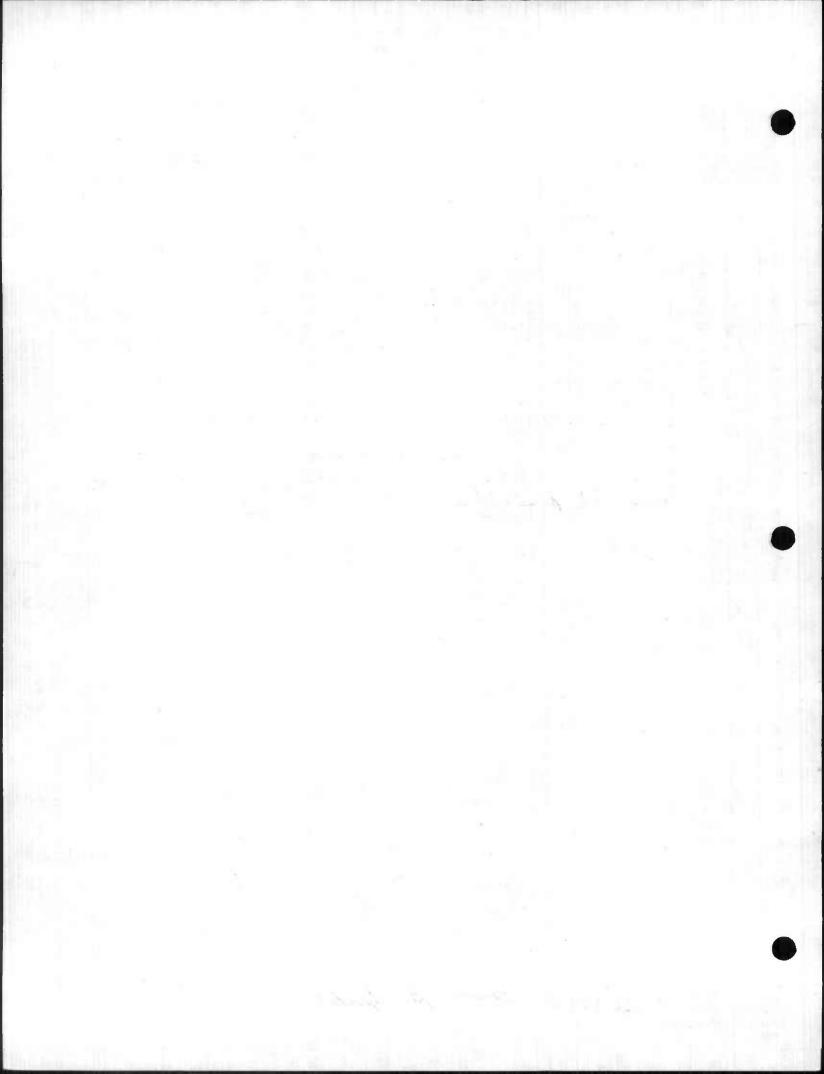
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Res No. 9 9 4 2 7 6 9

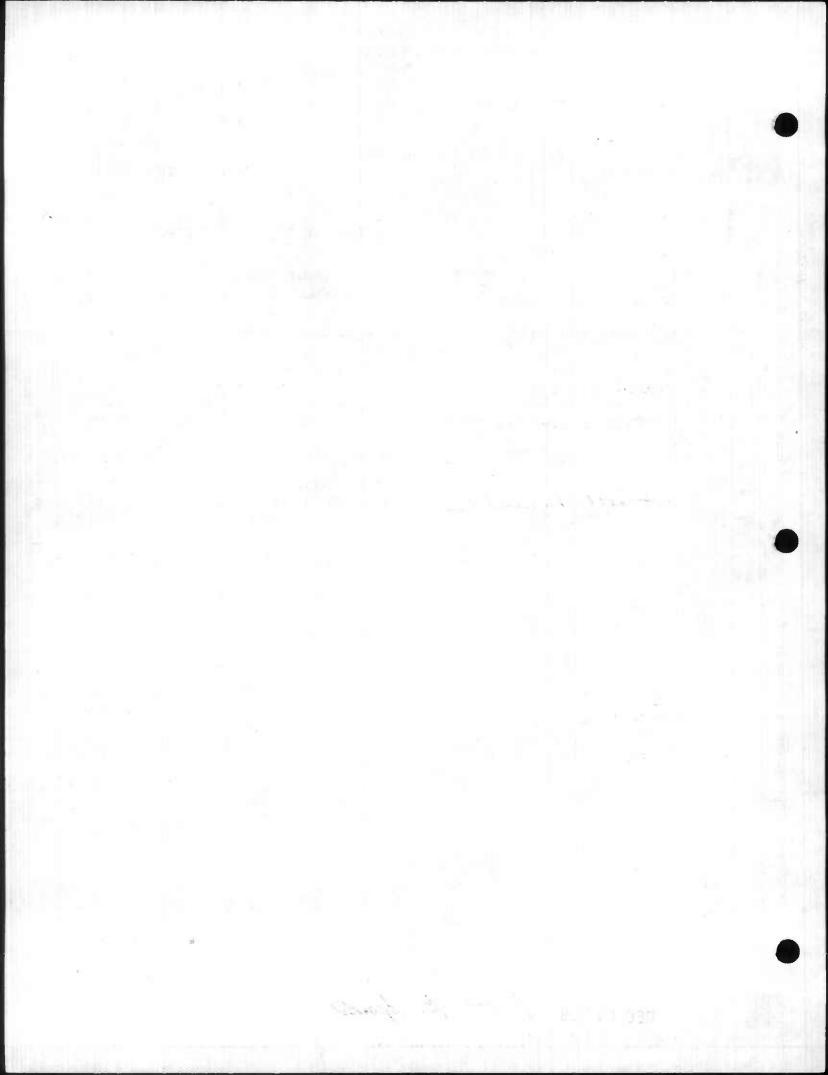
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	Decedent's Name (First, Mid	ldle, Last)			·			2. Date of Death Month		Year	3. Time of Death	
Physician /Modical	EDMUND								06:10 PM			
/Medical Examiner	4a Facility Name (If not instituti	ion, give street and number	r)			4b. City, To	wn, or Lo	cation of Death	4c. Count	ly of Death		
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uneral rector	5. Social Security Number 215–44–3246	Yrs. If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Date of Birth (Month, Day, Year) UNE 15,1924  9. Birthplace (State Country) ALTOONA,					
rector	Usual Residence of Decedent					1		JUNE 13,	1724	ABIO	ONN, III	
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	ROSANNA C. HOFFMAN, WIFE  20a. Method of Disposition    Suriel 2   Cremation 3   Removal from Stele 4   Donellon 5   Other (Specify)    CEDAR HILL CEMETERY   Date   CEMETERY											
	21. Signature of Funeral Service Licensea MOO866  22. Name and Address of Facility PARSELL FUNERAL HOME & CREMATORIUM, INC.											
	1449 KINGS HIGHWAY, LEWES, DE 19958  23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.  Approximate Interval Behonset and E											
nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in deeth)  a. Multiple Injuries  Due to (lefes e consequence of):											
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as been signed by the attending physician and 2 should be detached for use as the burial-trensit pleted by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a	consequence of):		ven in Part			a 200 No	3 □ Pro		
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State of Maryland / Department of Health and Mental Hygiene 9 4 2770

			Cei	rtificate of	f Death	Reg	J. No.	T too				
P1 1 1	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day	Year 3.	Time of Death			
Physician /Medical	GERTRUDE RIT	A HEAPS				DECEMBER			50 A.M.			
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death				
	BERLIN NURSING	CENTER			BERLIN			ESTER				
Funeral Director	5. Social Security Number 6. S  221–16–9051  Usual Residence of Decedent	DM 28E	yrs. last birthday)  Yrs.	If Under 1 Yes Months Day		8. Dete of Birth (Month, Day, )	(ear) 1918	9. Birthplace Country) TRAINE	(State or Foreign			
B # 41	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. le	nside City Limits			
vith the Mary t or 28a-f she be notified a	DE SUSSEX		SELBYVIL	LE 10f. Zip Code		100	1 □ Yes 2X No					
	3 OAK ROAD, KE	975	10g. Citizen of What Country? USA									
ural, or thems 23s at Examiner must ad by Funeral	11. Merital Status  1 Never Married 2 Merried  3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 Yes 2 N	Hispanic Origin? (Suban, Mexican, Puerlo O Specify:				E			
ygiene. Ner than "naturn It, the Medical. Completed	15. Decedent's Ed (Specify only highest gra	lucation de com <i>pleted)</i>	16a. Deced	16a. Decedent's Usual Occupation (Give kind of work done during most of wo			Sb. Kind of B	f Business/Industry				
and de	Elementary/Secondary (0-12)	College (1-4or 5+)		ESPERSO			RETA	TI				
	12 17. Father's Name (First, Middle, Last)		DIM	ILUI LIKDO		me (First, Middle, Ma						
rked off fic ever fo Be	JOHN A. MASLIN,				MARY							
-	19a. Informant's Name/Relationship (		19b. Mailir	a Address (Stre		ural Route Number, (	City or Town.	State. Zip Cod	(e)			
27.5	ELIZABETH M. LIG					SELBYVIL						
1 1 6	20e. Method of Disposition		0b. Place of Dispo		Ţ			City or Town,				
ary or	1  Burial 2  Cremetion 3  □ 4  Donation 5  Other (Specify		LAWN CROI			2/18/99 L	INWOOI	, PENN	SYLVANIA			
Departr Imports any inj adics.	21. Signature of Funeral Service Licensee MO0866  22. Name and Address of Facility PARSELL FUNERAL HOMES & CREMATORIUM INC.  1449 KINGS HIGHWAY, LEWES, DE 19958  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Interval Behveen Interval Behveen											
nding physician end use es the buniel-transit	Immediate Cause (Finat disease or condition resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting In death) Last	ones.	support Minut									
e attendir ed for use sician/	Part II. Other algorificant conditions or	ontributing to death but no	t resulting in the u	nderlying cause (	niven in Part I	23b. Did tob	acco use co	ntribute to the	cause of death?			
signed by the attendi Id be deteched for use d by Physician/I	Jenle,	Demen	La				23b. Did tobacco use contribute to the cause of c					
2 shou	High Blo	ood fr	esunq	2		performed? availe		availab	utopsy findings le prior to tion of cause h?			
rthis certificate har ral director, pege :: To Be Corm						1 □ Yea	2 No	1 ☐ Ye	s 2 No			
certificate rector, per	25. Was case referred to medical examiner?	Manadash.				ath (Check only one)						
this of all directions of the second of the	ILI 165 ZAJ NO		2 ER/Outpatien	I 3LI DOA		lome 5 Residen						
death. stor: Atter the tune	27. Manner of Death  1 Naturat 5 Pending investigation investigation determined	28e. Place of Injury -	At home, farm, str	M 1	☐ Yes 2 ☐ No	28d. Describe how	et and Num!		ute Number,			
within 24 hours after To the Funeral Direc completely filled in by Medical Certif	4   Homicide	building, etc. (S)		occurred at the	time, data and place	City or Town,		anner es eteted				
n 24 hound he Funer pletely fill edical	(Check only 2   Medical Exam	mer: On the basis of examend manner stated.	mination and/or im	restigation, in my	opinion, death occu	urred at the time, date	e and place,	and due to the	cause(s)			
To the	29b. Signeture and title of certifier	men	7		02026	290	Date signe	d (Month, Day,	Year)			
12	30. Name and address of person who of DR. FEDERICO ART			Print)	4	311 4	10-64	1-4400	•			
State	31. Date filed (Month, Day, Year)	A2. Registrar's S	/	low	,							



ASP

Physician /Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at 950s.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

				tificat				Mental Hy	Reg.	99	4	2111
1. Decedent's Nama (First, Midd TIFFANI		IAYMAN						2. Date of D Month DECH		Day R 29	Year 199	3. Time of Death 9 12:30 A
4a Facility Name (If not Institution ROUTE# 404 &	on, give street and num. WATTS CRE	10.0	GE			. City, To DENT		ocation of Dea	ith	c County		
5. Social Security Number 216-88-0810	6. Sex 1 ☐ M 25 ₹ F	. Age (In yrs. las 26	t birthday) Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D AUG. 1	ay, Ye		Co	hplace (State or Foreigr untry) YLAND
Usual Rasidence of Decedent 10a. State 10b. Count IARYLAND CAR	OLINE	10c. City,	Town or Lo									10d. inside City Limits 1 Yas 2 No
10e. Street and Number  208 ORIOLE	AVENUE			10f. Zip	Code 660			77 [	10g.	U.S.	What Co	untry?
11. Marital Status  1 □ Never Married ② Ma 3 □ Widowed 4 □ Divorce	12. Was Deced	<b>№</b> No	1	Was Deced	lent of His city Cuban	panic Ori , Mexicer Specify:	gin? (Sr , Puerto	pecity Yas or N Ricen, etc.)	lo-	Blad	ca - Ama ck, White y: WHI	
	nt's Education est grada completed)  College (1-		(Give	dent's Usua kind of wor DO NOT us MAKER	rk done du se retired)	ion ring mos	t of worl	king	16b	OWN		
17. Father's Name (First, Middle WAYNE WILSON	WHEELER					AI.	VIAN	ne (First, Middle  LEE Al	DAMS	3		
DONALD G. HAYM		BAND	208	ORIOL	E AV			IDGELY	, MI	21	660	
20a. Method of Disposition  1 ABurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (		tate cerr	etery, crer	sition (Name natory or o	ther place		1	-5-00				Town, Stata . 21601
21. Signature of Funeral Service  Language Part 1. Enter the diseasa, c shock, or heart failure. Lis	r complications that ca	C.F.S. usad the death. ch line.	P. 20	0 S.	WS,	HELF ISON	ENBE ST.	EAST	NC.			RAL HOME  Approximate interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a	Multip Due to (or a	o e s a consec	l n quence of):	uni	45						
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury		Due to (or a	s a consec	juance of):								
that initiated events resulting in death) Last		Due to (or a	s a conseq	uence of):								
	0											
Part II. Other significent condit	lons contributing to dea	th but not resulti	ng In the u	ndertying c	euse give	n in Part i			d tobac	412		to the causs of death

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit

Division of Vital Records, P.O. Box 68760,

completion of cause of death?

1 X Yes 2 □ No

1 Yes 2 No

25. Was cese referred to medical	26. Place of De	ath (Check only one)
axaminer? 1 □XYas 2 □ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H	Home 5 Residence 6 NOther (Specify) SCENE
27. Manner of Death 1 □ Natural 5 □ Pending 2 ■ Accident invastigati	18 88-71 8330	28d. Dascribe how injury occurred. Passenger in Motor vehicle accident
3 Suicide 6 Could not determine	building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State) Route 404
29a, Certifier 1□ Certifying P	Bridge on Route 404	Caroline County, Marylan

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DECEMBER 29, 1999 111 Penn Street, Baltimore, Maryland 21201

State Registrar

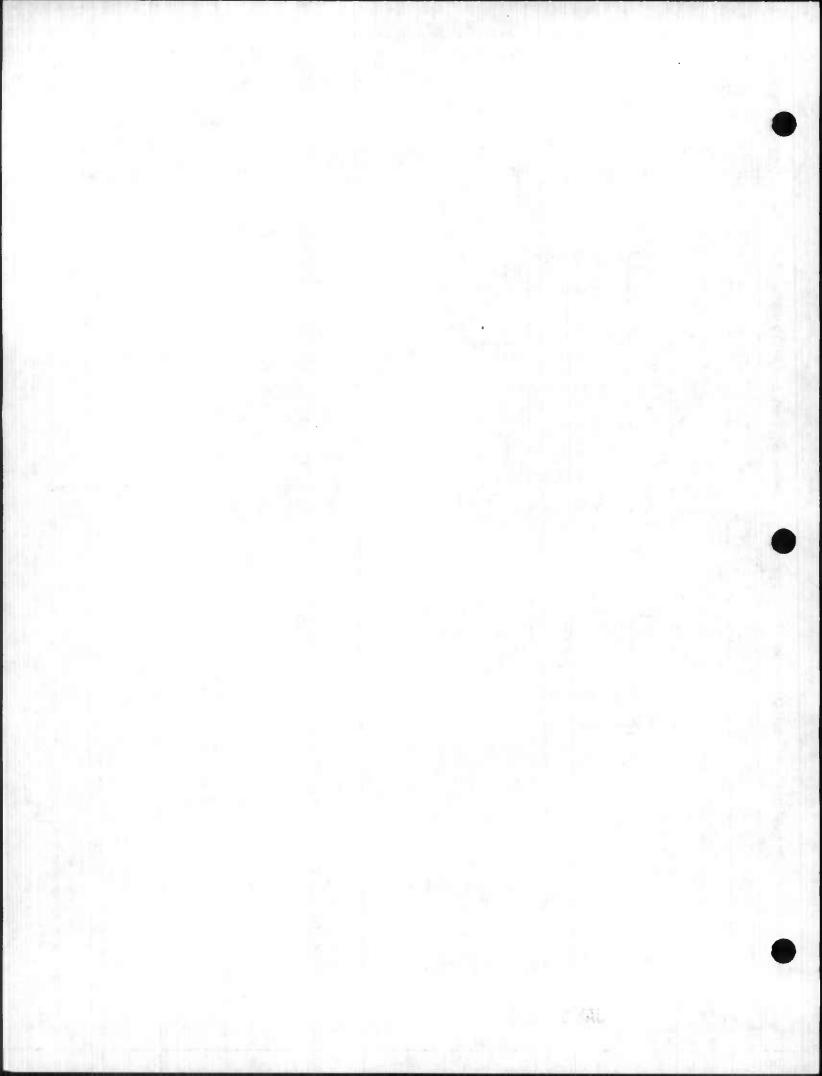
Stephen S.

31. Data filed (Month, Day, Year)

JAN 0 3 2000 Radentz 32. Registrags Signature

ooks

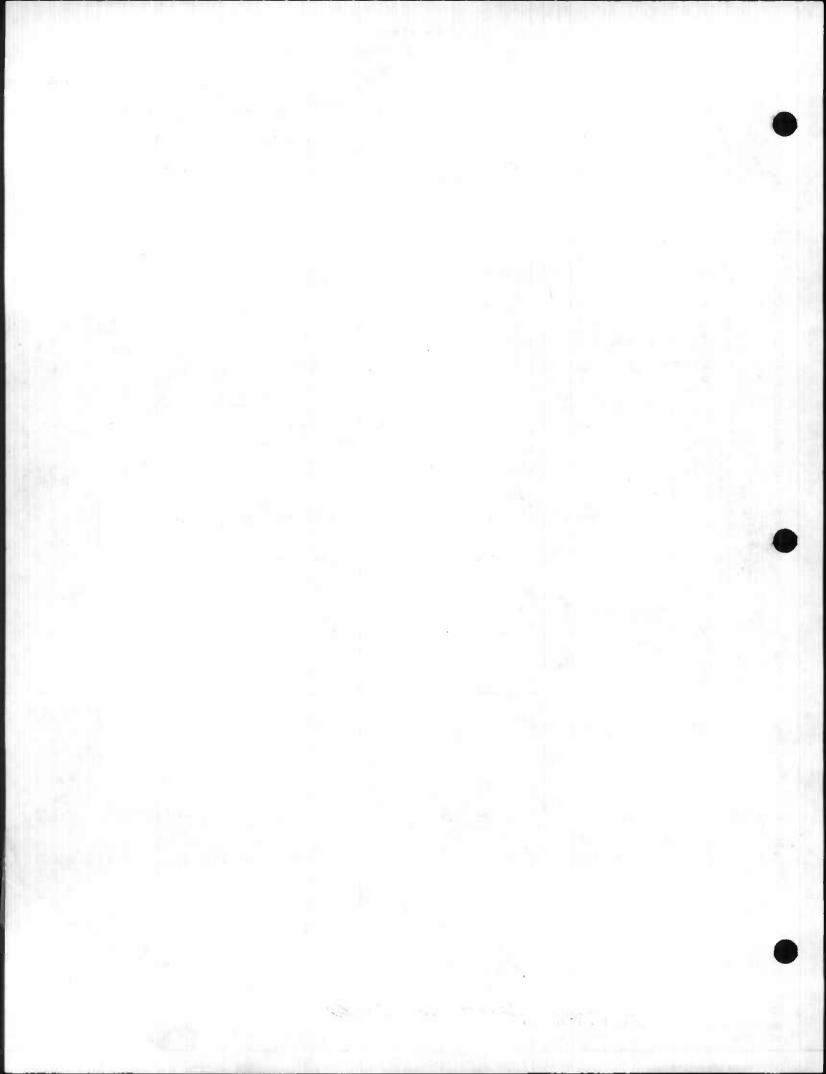
O.C.M.E



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician		ne (First, Middle, La:							2. Dete of De Month	, Day	Year	3. Time of De
/Medical	10		lones							nber 11,1		182
Examiner		(If not institution, give					48	b. City, Town, or I				
<u> </u>		SULA REGIO						SALISBU			COMIC	
Funeral Director	5. Social Security   266 - 90	-7700 1	ex □ M 2 2 7	. Age (In yrs.	last birthday,	Months	Deys	If Under 24 Hrs. Hours Min.	(Month, De	th y, Year)	9. Birthp Coun	iaca (Stete or Fo
2 .	Usual Residence of	10b. County		10c Cit	ty, Town or L	ocation					4	0d. Inside City L
with the Marylar a or 28s-f show be notified at												1 ☐ Yes 2%
or 28e-f a	Maryland			Sa	lisbur							
( ) ( ) ( ) ( ) ( )	10e. Street and Nu					10f. Zip	Code			10g. Citizen of 1	What Coun	itry?
ra in the	707 East	t Road					1801			US		
urs sher death v ur, or Neme 23s Examiner must by Funeral		ried 2 Married 4 Divorced	12. Wes Deced Armed Ford 1 Tas 2 If Yes, Give Year or Del	2⊠No	J,S. 13.	Was Deced If Yes, spec		spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Specify	ce - Americ ck, White, y: Bla	etc.
72 hor		15. Decedent's Ed	lucation		16a. Dece	dent's Usue	Occupa	tion		16b, Kind of B		
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C Marked		(First, Middle, Last)				0101		18. Mother's Nan	ne (First, Middle			
Mental H Mental H mrked off affic ever								Bert		Jon		
		iame/Relationship (1	Type Print)		10h Meili	ina Address	(Street e	nd Number or Ru	ral Route Numb			Code!
and 2 sho selfth and n 27 le m er traum			ypo, rinti									
C 25 M L	Terry Jor 20a. Method of Dis			20h F	Plece of Disp	osition (Nen	ne of	Neck RD	and US	13 West		
Pages net of my or o	1 Burial 2	☑Cremetion 3 □		tate	cemetery, cre	emetory or of	ther place					
T and	-	5 Other (Specif)		Sa.	lisbur	y Cren	nator	cy !	12/20/9	Salis	bury,	Maryla
Namit. Pages 1 as Department of Hea Important: If Nami Inty Injury or other Stick.	21. Signature of	unegal Service Licen	100	1 ,,	2	2. Neme en	d Address	s of Fecility 12	13 Jer	sey Road	d - Si	alisbury
4 605 a	Ya	Musa	11	Nolle	111	OLLEY	MEMO	ORIAL CH	APEL.		Mary.	land 2
Physician /Medical Examiner	Immediete Cause disease or conditi- resulting In death)	on	· At	hero s	close	1-	0	1	/	00	1	Onset end Dee
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ficate be executed to physician and to the burist-transit edical Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	5	ь. Нуре с. Нуре	Due to lo	or es e conse	quence of):	(ar	CLIO VASI	cular			Prior to
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2 0 4		Last	c. Hypes	Due to (co	or es e conse	quenca of):	10		23b. Dld		ontribute to	1986
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## RANDOLPH H. JOHNSON Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

42L		,	Certificate	e of Death	Re	g. No. 99	427	73
Dharainina	1. Decedent's Name (First, Middle, Last	)			2. Data of Death		Year 3. Ti	ma of Death
Physician /Medical	Randolph H		son, Jr.		DECEMBI	ER 29	1999 12	2:30 A
Examiner	4a Facility Name (If not Institution, give ROUTE# 404 & WA	street and number) ATTS CREEK BRI	INCE	4b. City, Town, or I	ocation of Death	4c. County of		
	5. Social Security Number 6. Se			DENTON  1 Year   If Under 24 Hrs.	8. Date of Birth	CARO		State or Foreign
Funeral Director		M 2□F 53	Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Dey, 8/12/		9. Birthplaca (S Country) Maryla	
N N	10a. State 10b. County		, Town or Location					Ide City Limits
ctor ctor	Md. Caroline	83]	17 Denton	Rd. Den	ton, Mo	d.	10	Yes 27 No
ust be notified rai Director	10e. Street and Number 8317 Denton Ro	ł.	10f. Zip	21629	10	U.S.	hat Country?	
Examiner must be notified at by Funeral Director	11. Maritat Status  1 Meever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:		ent of Hispanic Orlgin? (Sify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)		- American fndi c, White, etc. Blac	
went, the Medical Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cetion	16a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of wor.	king	LAC		
Be Co	17. Father's Neme (First, Middle, Last)		1 2 40,		ne (First, Middle, N			
To Be C	Randolph H. Jol	nnson Sr.		Sadie :	Evans J	ohnson		
-	19a. Informent's Name/Retationship (T)	rpe, Print)		(Street end Number or Ru				
E E	Randolph H. Jol			nton Rd. De				
90	20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	tace of Disposition (Nem	ther plece)	1 .		City or Town, Sta	
dans.	4 Donation 5 Other (Specify)		.V eterans		1/3/00	Belun	Maryla	ına
800	21. Signature of Funeral Service Licens	behall	Eric	d Address of Facility C. L. Dashi East Ave.	ell F. Easton	S. Maryla	nd 216	01
	23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death ne cause on each line.	n. Do not enter the mode	e of dying, such as cardiac	or respiratory arre	est,	Interv	eximate al Between t and Death
ician dical	tmmediate Cause (Final	44		C.				
iner	disease or condition resulting in death)		ras a consequence of):	uries				
e e		Due to (or	ras a consequence or).					
edical Examiner	Sequentially list conditions,	Due to (or	r as a consequence of):					
al E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	d						
pdica	that initiated events resulting in death) Lest	Due to (or	as a consequenca of):					
6		d						
od for	Part It. Other eignificant conditions con	ntributing to death but not resu	ulting in the underlying o	euse given in Pert f.	23b. Did to	bacco uee con	tribute to the c	sues of death?
Physician							3 Probably	
by b								
page 2 should be detached for use Completed by Physician/N					24a. Was a perform	n autopsy ned?	24b. Were aut avaitable completic of death?	prior to on of cause
director, page 2					1 DXY6	s 2 No	1 De Yes	2 No
Be (	25. Was cese referred to medicet examiner?				th (Check only on	e)		
To	1 Yes 2 No		ER/Outpatient 3□ DO		ome 5 Reside			CENE
funer fon:	27. Manner of Death  1 Neturet 5 Pending	28a. Dete of tnjury (Month, Day Year)		8c. tnjury at Work? 1 ☐ Yes 2 ☑ No	28d. Describe ho	w injury occurr		
ficat	2 Accident investigation 3 Suicide 6 Could not be	12 - 28 - 99 28e. Place of Injury - At ho	2356 M			vehicl reet end Number		e Number.
ert	4 ☐ Homicide determined	building, etc. (Specify Watts Creek	"	1	28f. Location (St City or Town			yland
completely filled in by the funeral director,  Medical Certification: To Be (	29e. Certifier 1 Certifying Physical Examination	etclan: To the best of my knowner: On the basis of examinat	wiedge, death occurred	et the time, date end plece	, end due to the ca	use(s) and ma	nnar as stated.	
Mec	29b. Signature and titte of certifier	and manner stated.	290	. License number	2	9d. Date signed	I (Month, Day, Y	'ear)
6	11-11	1 1/1 m al	To MA	O.C.M.E			29,199	
	30. Name and address of person who co	empleted ceuse of death (flam	23a) (Type, Print)					
	- A	-adentz, M		Penn Street	. Baltim	ore. Ma	rvland	21201
State	31. Date filed (Month, Days Your)	32. Registrar's Signat		/			- June	M TEV T

#### Piease Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month EVA VIRGINIA LISTER 31 1999 Dec 0816 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Memorial Hospital Talbot Md If Linder 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birtholece (Stete or Foreign Year 1926 Hours MARYLAND 73 Yrs. 218-20-8967 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 JUDAS STREET 21601 U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - American Indien, Black White etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 -0-SECRETARY MEDICAL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) OTTO H. KAUFMAN MARTHA EDNA PATCHETT 19e Informant's Neme/Relationship (Type Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) J. PAUL LISTER / HUSBAND 22 JUDAS ST. EASTON, MD. 21601 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) DENTON CEMETERY 1-4-00 DENTON, MD. 21. Signeture of Funerel Selvice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. serviam 200 S. HARRISON ST., EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy completion of cause of death? 2 200 1 Yes 1 □ Yes 2 □ No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic avant, or a had any injury or other traumatic avant, or

**Physician** 

/Medical

Examiner

Director

Funeral

p

Completed

Be

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**Funeral** 

Director

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r than "natural", or hema 23a or 28a-f ahov the Medical Examiner must be notified at

with the Meryland

deeth v

hours after

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

The law requires that the death certificate be executed Physician/Medical been signed to should be det à Completed page 2 certificate or Attanding Physician: funeral director, Be Certification: To this After death. 24 hours after deat Funeral Director:

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29b. Signeture and title of certifier 29c. License number Vovo am 30. Neme and address of person who completed cause of death (Item 284) (Type, Print)

29d. Dete signed (Month, Day, Year)

WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVE. EASTON, MD. 21601

State Registrar

filled in by

completely

within 2 4

Medical

29a. Certifier

(Check only one)

Hospital

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

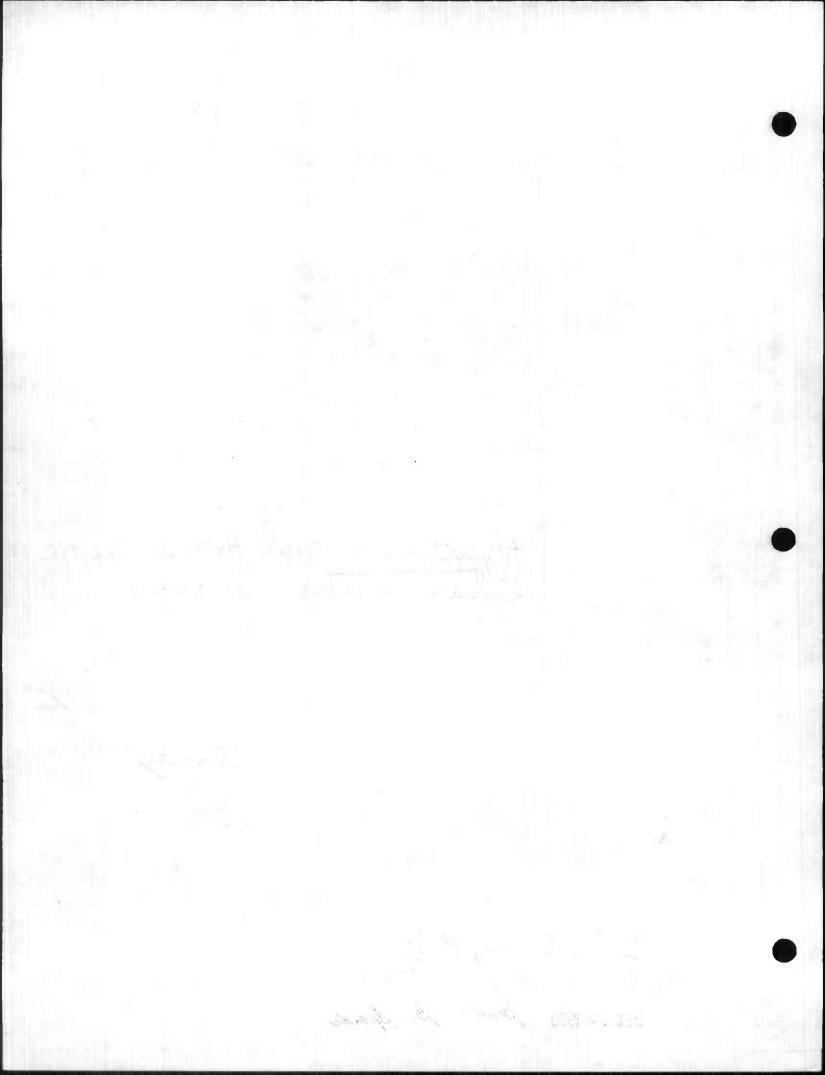
2 Wedical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

Please	Type or	Print in	Biack	indelible	ink.	Assure	All	Copies	Are	Legib
	01.1.		1.45		- 6 1 1	101	0.00			

State of Maryland / Department of Health and Mental Hygiene Kermit M. Maddox Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** KERMIT MADDOX December 09 1999 10:00AM. /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 8575 Old Westover Marion Road Westover Somerset If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□ F 219-01-9112 89 Director Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Somerset 288-1 Westover 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code b Berns 23a 7585 Old Westover/Marion Road 21871 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after of Hygiene. other then "natural", or liter 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
tifle, DO NOT use retired)
SETT-EMPLOYED interior/exter 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Somerset County decorator & bus contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Artie Maddox Rosena Collins 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: if Item 27 is any injury or other tra Michael Ballard/son 6534 Afterglow Lane - Indian Trail, NC 28079 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) John Wesley Cemetery 12/16/99 Princess Anne, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility 1213 Jersey Road - Salisbury, MD retta JOLLEY MEMORIAL CHAPE 23a. Part 1. Enter the disease, or complication, that caused the d shock, or heart lailure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner OVasc The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of): 980 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24a. Was an autopsy \_\_\_\_\_ nerformed? \_\_\_\_ 24b. Were autopsy lindings available prior to uspection completion of cause of death? page 2 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XYes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No death. To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the filled in by the filled in the filled 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

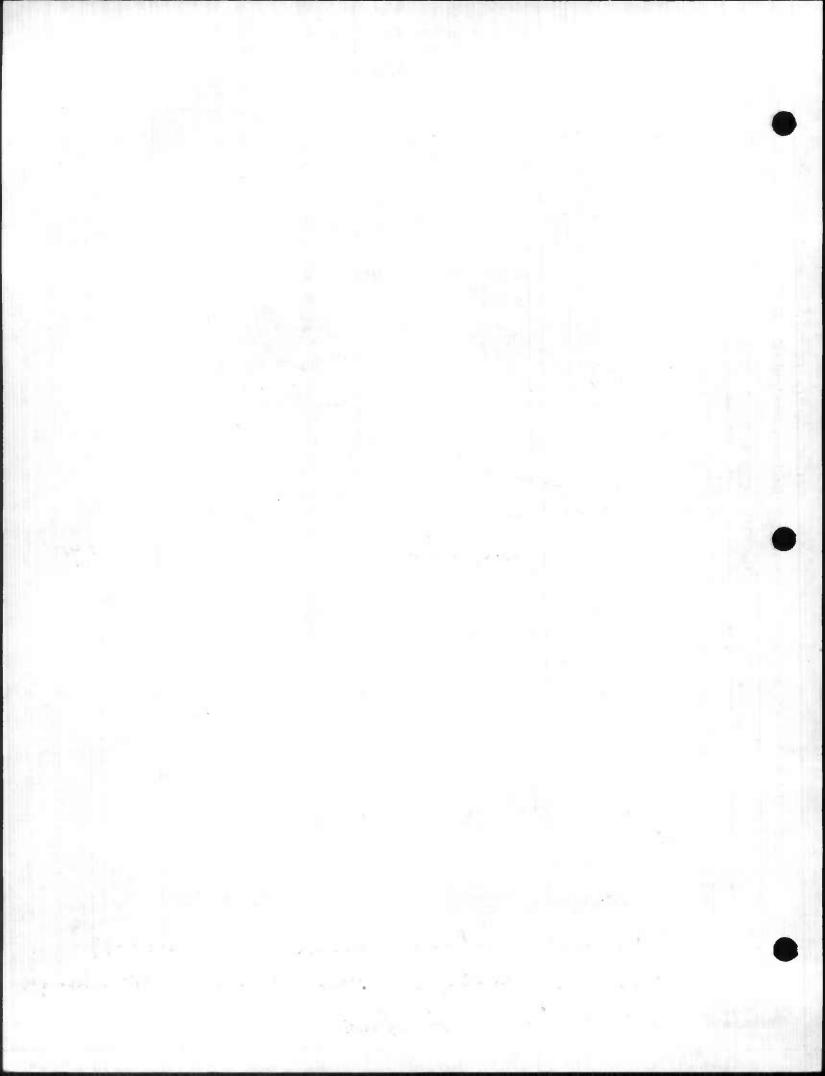
\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. Medical 29e. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 10, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) taner 62. 10 S 111 Penn Street, Baltimore, Maryland 21201 (Month, Dey, Year) 32 Registrer's Signature State 15 1999 Registrar



## Fluiding Tell and Moore  ## Fluiding Tell and Moore  ## Fluiding Tell and Moore  ## Fluiding Tell and REG IONAL MEDICAL CENTER  ## Social Security Number    5. Social Security Number   6. Sex   7. Age (in yrs. last birthday)   8. Bunder 1 Year   10. Centrol of Death   10	10
PENINSULA REGIONAL MEDICAL CENTER  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Social Sec	me of Dea
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11. Mented Status 1   Newer Merried 2   Oktamined 2   12. Wes Dependent Ever in U.S. Armedic rices; 1   17 kes, peoply (1906). Mexican, Public, Microscol. Public, etc. 1   Okes 2   No.   1   Ves. 2   No.	
Treamer's Memore (Pirst, Mindow, Maiden Sumanne)   Treamer's Memore (Pirst, Mindow, Maiden Sumanne)	en,
17. Path of a Name (prist, Modes, Last)   18. Mother's Name (prist, Modes, Macken, Sumame)   18. Mother's Name (prist, Modes, Macken, Macke	
17. Father's Neme (risk, Modine, Lats)	
19e. Informer's Neme/Relationship (Type, Print)  19e. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Rosalee Moore/Wife  P. O. Box 24, Hebron, MD 21830  20e. Method of Disposition 3 (Demovel from Stete 4   Donetion 5   Other (Specify) or Town, State, Zip Code)  20e. Method of Disposition 1 (Name of cemelety, cremetally contributed from Stete 4   Donetion 5   Other (Specify) or Town, State, Zip Code)  21. Signature of Fundal Service List change  22. Name and Address of Facility  Lewis N. Watson Funeral Home  1618 West Rd., Salisbury, MD 21801  23a. Part Leiner the Sealed or Phomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Immediate Cause (Fired disease or condition resulting in deeth)  23a. Part Leiner the Sealed or Phomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Immediate Cause (Fired the Sealed or Phomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Immediate Cause (Fired the Sealed or Phomplications or Phomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Immediate Cause (Fired the Sealed or Phomplications or Ph	
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Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801	
1618 West Rd., Salisbury, MD 21801   23a. Pgft Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.   Appropriate the property of the property	
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25. Wes case referred to medical examiner?  26. Place of Deeth (Check only one)  27. Menner of Death 1. Returel 2 Accident 3 Suicide 4 Homicide  28. Place of Injury 4 Month, Dey Year)  28. Injury at Work? 4 North Dey Year)  28. Injury at Work? 5 Pending investigation 3 Suicide 4 Homicide  28. Place of Deeth (Check only one)  28. Injury at Work? 1 Yes 2 No  28. Injury at Work? 1 Yes 2 No  28. Place of Deeth (Check only one)  28. Injury at Work? 1 Yes 2 No  28. Injury at Work? 28. Injury at Work? 28. Injury at Work? 3 Suicide 4 Homicide  28. Place of Injury - At home, ferm, street, fectory, office  28. Place of Deeth (Check only one)  28. Dete of Injury - At home, ferm, street, fectory, office  28. Place of Deeth (Check only one)  28. Dete of Injury - At home, ferm, street, fectory, office  28. Place of Deeth (Check only one)  28. Dete of Injury - At home, ferm, street, fectory, office  28. Place of Deeth (Check only one)  28. Dete of Injury - At home, ferm, street, fectory, office  28. Place of Deeth (Check only one)  28. Place of Deeth (Check only one)  28. Place of Deeth (Check only one)  28. Place of Deeth (Check only one)  28. Place of Deeth (Check only one)  28. Place of Injury - At home, ferm, street, fectory, office  28. Injury at Work?  1 Yes 2 No  28. Location (Street end Number or Rurel Route City or Town, State)  29. Certifier (Check only one)  29. Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.  29. Dete signed (Month, Day, Yes)	2 No
27. Menner of Death 1. Neturel 2   Accident 3   Suicide 4   Homicide  28a. Dete of Injury 4   Location (Street end Number or Rurel Route City or Town, State)  28b. Time of Injury 4   Location (Street end Number or Rurel Route City or Town, State)  28c. Injury at Work? 1   Yes 2   No  28d. Describe how injury occurred  28d. Descri	
3   Suicide 4   Homicide   28e. Plece of Injury - At home, ferm, street, fectory, office   28f. Location (Street and Number or Rural Route City or Town, State)   29a. Certifier (Check only one)   29d. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.   29b. Signature and little of certifier   29c. License number   29d. Dete signed (Month, Day, Y	
29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.  Check only one)  29b. Signeture end little of certifier  29c. License number  29d. Dete signed (Month, Day, Y	Number,
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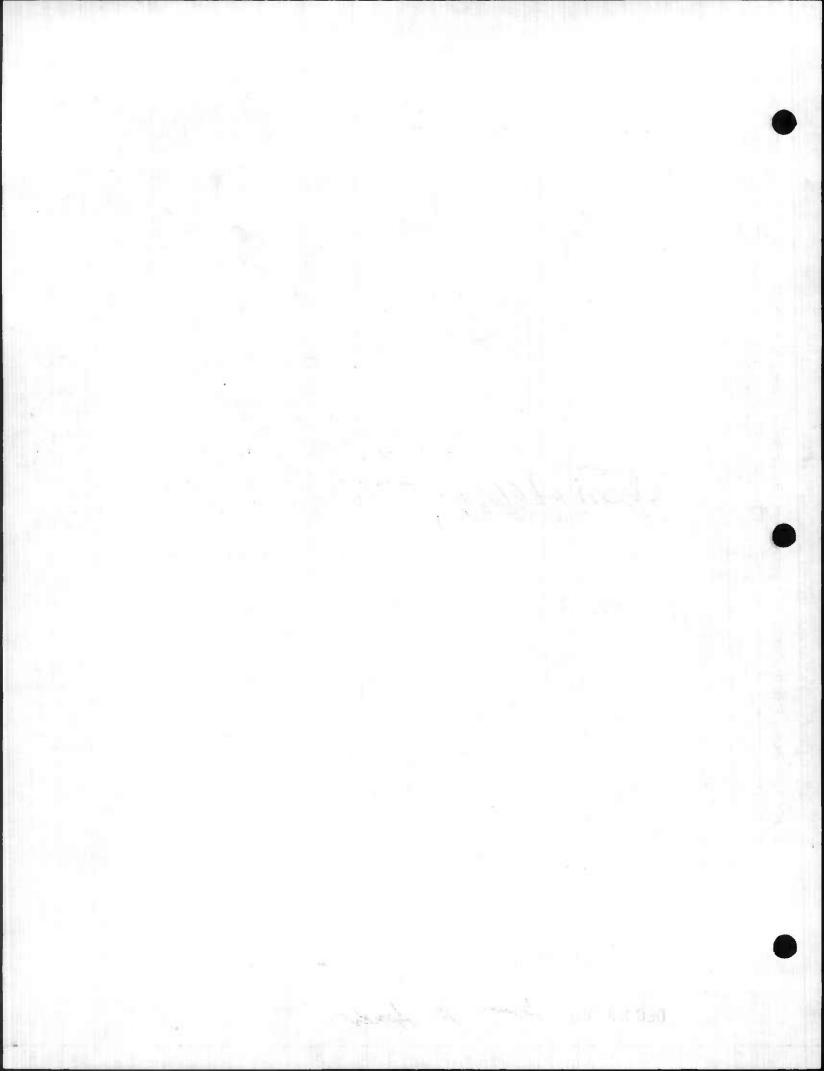
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dar **Physician** 0415 RCEMBER 23 1999 ROBERT RICHMOND MEALY /Medical 4e Facility Neme (II not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 € M 2 F **Director** June 4,1914 212-10-4281 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Worcester Bishopville 1 Yes 2 No Director 258-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 23a or 10931 Piney Island Dr. 21813 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? hours after 1 √ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WW II White Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Salesman Automotive Fabrics 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 ahould be in ment of Health and Mental H tart: If them 27 is marked off jury or other traumatic ever Be Guy Mealy Laura Richmond 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Ednell Mae Mealy/Wife 10931 Piney Island Dr., Bishopville, MD 21813 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State Wicomico Memorial Park 12/27/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease disease or condition resulting in death) Chronic Examiner Due to (or as e consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): for use I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 12 Yes 2 No 3 Probably 4 Unknown preumaca Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vitai Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2□ No 1. Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending investigation Division or Attending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and member steted. edical (Check only one) within 2 29b. Signeture end title of Confine 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Salisbury MD 2180 hartos Sitvia 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar DEC 23 1999

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	NA+ 12	1	30 Name and address of person	// 1	MA Zause	4C/	tem 23ay	·ype,	175	7.		Sa	lish		MI	) 2	1801	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** VIOLET MILLS DECEMBER 18, 1995 0540 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 1DM 2DF Days Months 80 215-16-8701 Director OCT. 4,1919 MARYLAND Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ¥ Yas 2 No Director MARYLAND WICOMICO FRUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21826 U.S.A. Items 23s Funeral 631 CLYDE AVE. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. pamit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 Ĭ Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) RETAIL STORE 11 MANAGER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) VERNON EDWARD KTLLTAM M. GWENDOLYN HARRISON 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) WILLIAM K. MILLS 631 CLYDE AVE. FRUITLAND, MD 21826 Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 Cramation 3 Ramoval from Stata HEBRON CEMETERY 4 □ Donation 5 □ Other (Specify) 12-20-99 HEBRON, MARYLAND 21. Signature of Funeral/Sarvice Licensaa 22. Nama and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part 1. Entar tha diseasa, or complications that cased the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) CARD 10 RESPIRATORY

Due to (or as a consequence of): IMMEDIATE Examiner SEVERE HYPOX (A

Dua to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or Injury that Initiated evants rasulting in death) Last Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Certification: To Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTE NUION HRTHRITI GLAUCOMA 1 Yes 2 No 1 Yes , 2 No Division of Vital or Attending Physician: 25. Was casa refarred to medicel examinar? 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Invastigation within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. within 2 29c. License number 29d. Data signed (Month, Day, Year) 00055006 140

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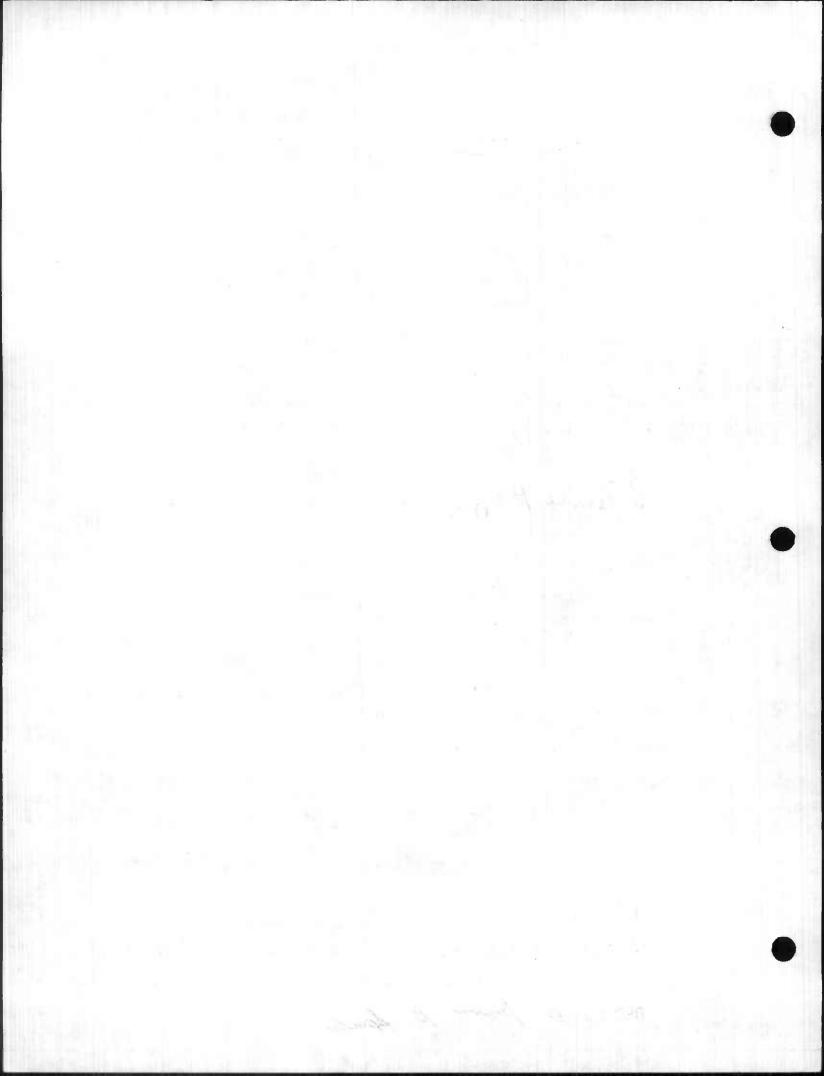
y, Year) 32/Registrar's Signatura

30. Nama and address of person who completed ceuse of death (Itam 23a) (Type, Print)

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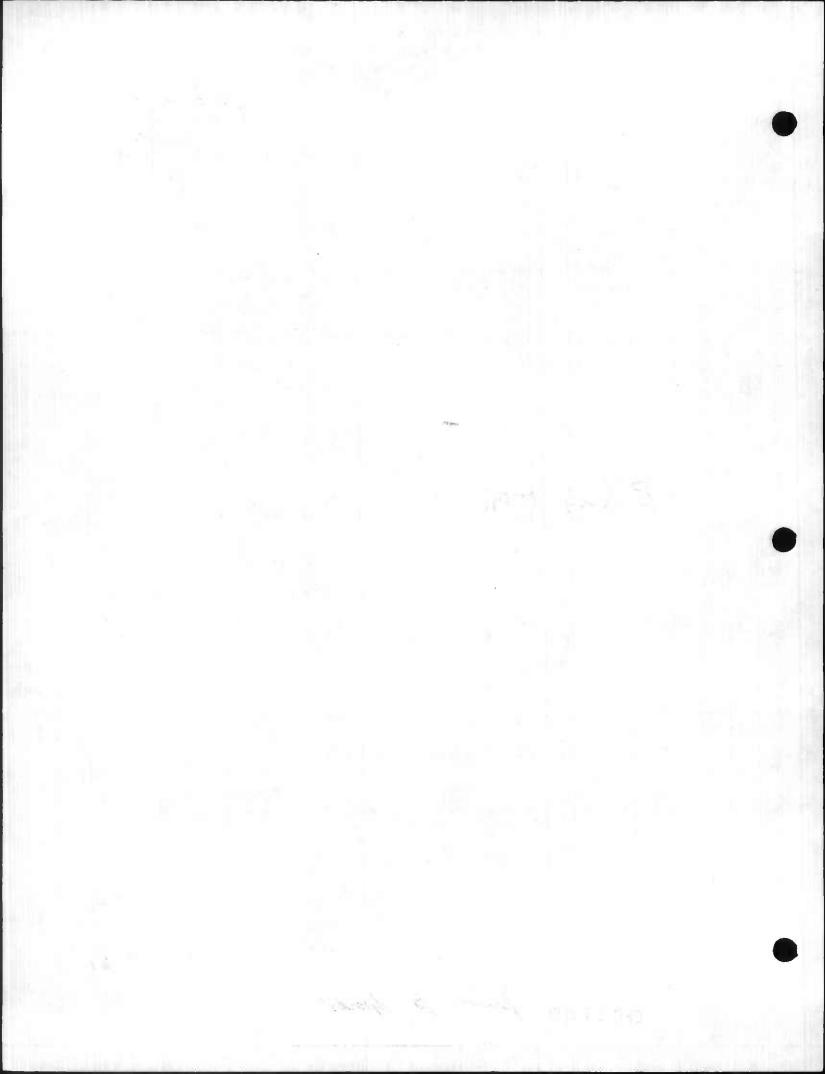


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State of Maryland / Department of Health and Mental Hygiene 9 9

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Physician	1. Decedent's Name (First, Midd	fle, Last)							2. Date of Do	Day	Year	3. Time of Death
/Medical	HELEN	FLORENC	E	MA	SSEY				DECEMBI	ZR 15,	1999	6:15 P.M
Examiner	4a Facility Name (If not institution		ımber)			- 1	4b. City, To	wn, or L	ocation of Deal	h 4c. Count	y of Death	
	BERLIN NURSING	HOME						BERL			ORCES	TER
Funeral	5. Social Security Number	6. Sex 1  M 2  F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth sy, Year)	9. Birthp	lace (State or Foreign try)
Director	218-48-5731	IUM 28F	83	Yrs.						0,1916	DELA	
	Usual Residence of Decedent  10a. State 10b. Count	,	100 Ci	ty, Town or Lo	ontion						1.	0d. Inside City Limits
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or 28e-f s be notified Director	10e. Street and Number				10f. Zip					10g. Citizen of		itry?
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iner 234 iner mat	11. Marital Status	12. Was Dec	cedent Ever in U orces? 24 No	,S. 13. \	Vas Deced I Yes, spec	ent of H ify Cuba	lispanic Or an, Mexica	igin? (Sp n, Puerto	pecify Yes or No Rican, etc.)	o- 14. Ra Ble	ce - Americ ick, White,	
by F.	1 Never Married 2 Ma	H Vac G	NO BY		□ Yes	O No	Specify.	- 17		Specia	v: WH	ITE
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al Hygiena. I other than "natur went, the Medical. Be Completed	15. Decede (Specify only high	nt'a Education est grade completed,		16a. Deced	lent's Usua kind of wo	k done	etion during mos d)	t of worl	king	16b. Kind of B	Businass/Inc	dustry
E E	Elementary/Secondary (0-12)	College	(1-4or 5+)							OT TAX	Y1 A TXX 6	
STE O	17 Fetharia Nama /First Middle	Local		POULT	RY FA	KME		de Nom	a Cina Adiatalla	OWN		
	17. Father's Name (First, Middle ABE	LAYTON								, Maiden Sumai	1116/	
후본은 은								OREN		ALHOUN		
Health and K Hem 27 is ma	19a. Informant's Name/Relation		IN-LAW							er, City or Town	, State, Zip	Code)
m 27 her	CONNIE E. MASSI	EY - DAUGH					VE RD	. W	ILLARDS		21874	
o m o	20a. Method of Disposition 1 Durial 2 Ocremetion	3 □Removal from	Stale 200. F	Place of Dispo cemetery, cred	natory or o	her plac	09)	i	Date	20c. Location	- City or To	wn, State
martin mark	4 □ Donation 5 □ Other (S			MBRIDG	E CRE	MAT(	DRY	1	2/16/99	CAMBR	IDGE,	MARYLAND
Post Fig. 19	21. Signature of Funeral Service	Licensee /			. Name an	d Addre	ss of Fecili	ty		705 E.	MAIN	ST.
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	23a. Part1. Enter the disease, of	complications that	caused the deat								BUKI,	Approximata
	shock, or heart failura. Lis	t only one cause on	aach line.								i	Interval Between Onset and Death
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xaminer	disease or condition resulting in death)	a. (7) C	Due to (c	m	500	an	idi	41	1 M	Fret	1	00025
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butal-transit butal-transit	Sequentially list conditions,	1	Due to (d	or as a consed	uence of):						/	
cian Suria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	nte	nio	10	1	No	541				
physician and is the burial-transit	that initiated events resulting in death) Last		Due to (o	r as a conseq	uence of):	1						
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bend &	- eceny	-010	-Cen	ebn,	0 /	00	CUI	BN	- <u> </u>			
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ahoui	Jen !	4							pen	omear	CO	mpletion of cause death?
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o Gest	25. Was case referred to medical				_		00 DI				1	1 1 482 248 MO
s certificate has t director, page 2 a To Be Compli	examiner?  1 Yes 2 No	Hospital:	Annual	5010		Oth			th (Check only	_		
E E	27, Manner of Death	10		ER/Outpatien 28b. Time of		A	463 N	ursing H		idence 6 Ot		y)
After	1 X Natural 5 ☐ Pendi		of Injury oth, Day Year)	Injury	M	Bc. Injur Wor	k? Yes 2□	No	200. 2000/120	injury cocu		
or deeth.  octor: After this certific by the funeral director, iffication: To Be	3 Suicide 6 Could	not be	and faithers than				103 2	.40	201 Leasting	(Street and M.	har or D	I Douda Alientes
in by	4 Homicide determ	nined 200. PIEC	e of Injury - At he ling, etc. (Specif	y) y)	et, ractory	, OTTICE				wn, State)	Der of Mura	Il Route Number,
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:												
Fune lely fi	(Check only 2   Medical	ng Physician: To the Examiner: On the b	asis of examina	wledge, death tion and/or inv	occurred a	it the tin	na, date ar pinion, des	d place, th occur	, and due to tha rred at the tima.	date and place	annar as s	tated. the cause(s)
within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	one)	and mar	ner stated.									
Too Son	29b. Signeture end little of surfills		2	)	290	Licens	e number			29d. Dete sign		
	///	///		/	1	0020	26			12-1	16-9	G
	30. Name and address of person	who completed cau	se of death (limin	23a) (Type,	Print)							1
	DR. FEDERICO	ARTHES, M	D 46 T	EAL DR.	. REI	RL.TN	, MD	2	1811	410-641	-4400	)
State	31. Date filed (Month, Day, Year,	32/1	Pegistrac'a Signa		Space	1		the .	~~1	110 041	1700	
Registrar	DEC 171	999	-	1	MANOR	A ST						

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Neme (First, Middla, Last) 3. Tima of Death William Month **Physician** Markel 31 1999 02:52AM DECEMBER /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 120 M 2□ F 7. Aga (In yrs. last birthday) Birtholaca (Stata or Foreign Country) **Funeral** Hours Days Months Yrs. Director 5 26,1999 Maryland Usual Rasidence of Decedant The Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits show 1 Yas 2 No Director 25a-f Maryland Worcester Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be a 319 Chesapeake Funeral Ave. 21817 USA 12. Wes Decedent Ever In U,S.
Armed Forces?
1 Yes 2 2 No
If Yas, Giva 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Meritel Sfetus filed within 72 hours after 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 Infant Infant 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumama) Be To William Green, Sr. Tyshonna 19a. Informant's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Tyshonna Miles, mother 319 Chesapeake Ave., Crisfield, Maryland 21817 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 D Buriel 2 Crametion 3 Ramoval from Stata Mt. Piere Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 1/8/2000 Marion, Maryland 22. Name and Addrass of Facility
Bennie Smith Funeral Home 21. Signatura of Funaral Service Licenses P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Final a. Respiratory Distress

Due to (or as a consequence of): Syndrome diseasa or condition rasulting in deeth) Examiner Physician/Medical Examiner Prematurit the burial-transit Hospital or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Dua to (or as a consequenca of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed a Division of Vital Records. þ 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No certificate 8 25. Wes case refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) edical Certification: To this funeral Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accidant 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, ferm, streef, fectory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, death occurred et the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated. 29e. Certifier To the

State Registrar

29b. Signeture end fitte of certifier

Henry C Boggetto

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

1114 William

Bagge #

31. Deta filed (Month, Day AN) 0 5 2000 32. Registran Signatura

Street

29c. License number

RES-00

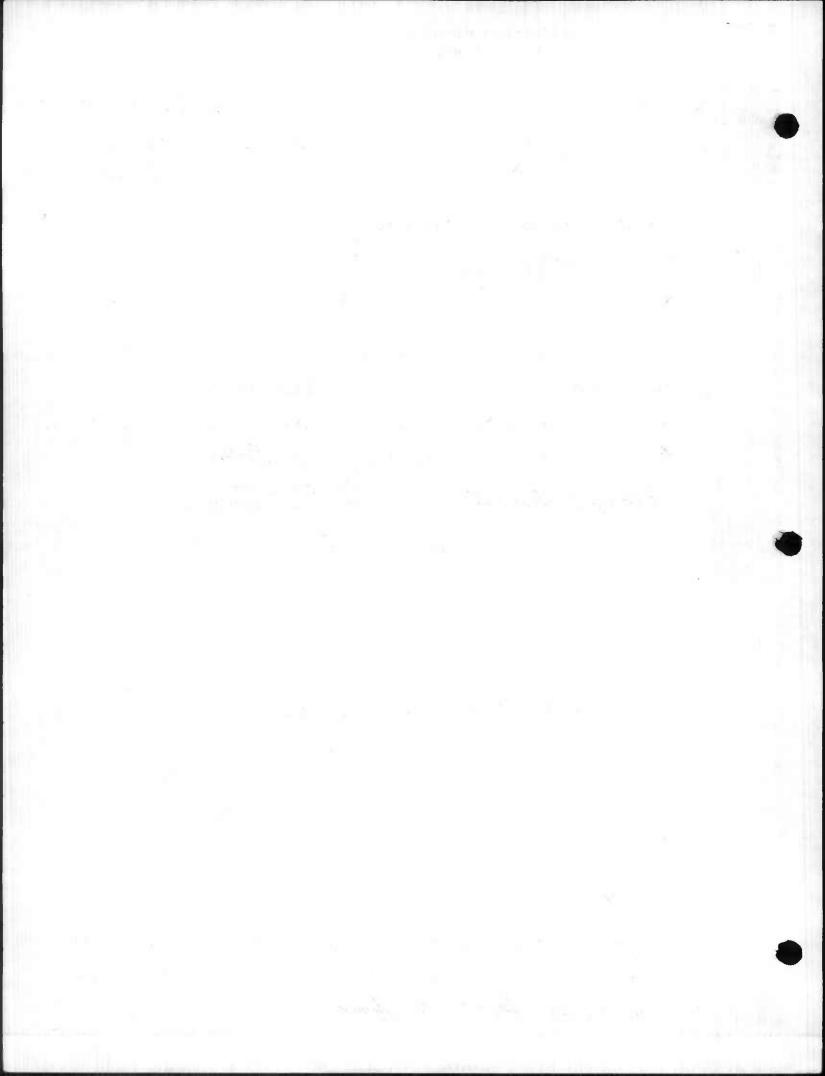
Baltimore, MD 21230

29d. Date signed (Month, Day, Year)

12/31/99

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Maryland / Department of Health and Managed # 2 / 12/16/99/ WCHD/ HLC Certificate of Death		00	1.2700
			Decedent's Neme (First, Middle, Last)	2. Date of De	Reg. No. 33	3. Time of Deeth
	Physici		Sarah Louise Polson	Month	Dey 13	Yeer 1:30 pm
	/Medic Examir		4a. Fecility Neme (If not institution, give street end number)  4b. City, Town, or L	ocation of Deet	h 4c. County o	of Deeth
1			608 Morris Street Salisbu	ıry	Wico	mico
	Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs.  Months Devs Hours Min.	8. Dete of Bir (Month, De	th by, Year)	Birthplace (State or Foreign Country)
	Director		103-20-3040	Dec.4	1934	Pennsylvania
	pue *		Usuel Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Location		· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	Merylen f show	o	Maryland Wicomico Salisbury			1 ☐ Yes 2 No
	28e	Director	Maryland Wicomico Salisbury  10e. Street and Number 10f. Zip Code		10g. Citizen of W	het Country?
	13a o	al D	608 Morris Street 21801		U.S.A	
	ours efter death with the Meryle ral', or items 23s or 28s-f show Examiner must be notified at	Funeral	11. Maritei Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Wes Decedent of Hispenic Origin? (Sp. 14 Maritei Status)  14. Maritei Status  15. Wes Decedent of Hispenic Origin? (Sp. 15 Maritei Status)	pecify Yes or No	- 14. Rece	- American Indien,
0	or its	/ Fu	1 Never Merried 2 Married 1 Yes 2 No	riioari, etc.)	Specify:	t, vanite, etc.
21215-0020	within 72 hours efter death with the Meryland ana. than "natural", or items 23s or 28s-f show ha Medical Examiner rout be notified at	d by	3 NWidowed 4 □ Divorced Yeer or Detes:			Black
15	d within 72 h jiena. r then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired]	king	16b. Kind of Bus	siness/Industry
212	filed withi Hygiena. rther then	dmc	Elementery/Secondery (0-12)  College (1-4or 5+)  Beautician		Beauty	Calon
	등수품부	Be C		e (First, Middle	, Maiden Surneme	
lan	should be filed withind Mental Hygiena.  marked other than Imatic event, Italy	To B	Robert White Alene	Feltor	1	
Maryland			19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rus	ral Route Numb	er, City or Town, S	Stete, Zip Code)
	is 1 end 2 of Health e from 27 is other tra		Parthenia White (Sister) 53 Harry S.Turman D	R.Apt.	22 Lar	go, Md. 20774
Baltimore,	00-		20e. Method of Disposition  1 ■ Buriel 2 □ Cremetion 3 □ Removel from State	Date 2/150/	20c. Location - 0	City or Town, Stete
Ë	Pa Int:		4 □ Donetlon 5 □ Other (Specify) Springhill Mem.Garden	7999	Hebron	,Md.
3ali	permit. Departr Imports any Inju		21. Signeture of Funerel Service Licensee  22. Neme end Address of Fecility Stewart Funeral	Home		
_	40 E 4 0		Blody B. Stewart 821 West Rd. Sali		.Md.218	01
			23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or hear dilure. List only one cause on each line.	or respiretory e	rrest,	Approximete Intervel Between
	Physician / /Medical		Immediate Cause (Finel			Onset end Deeth
	Examiner		resulting in death) e.			10
		- e	b. Mol-Stage Kidney	die	nco	1 year
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o,	cate be axecuted physicien end s the burial-transit	EX	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury			
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Вох	eath certif attanding for use a	lan/	<b>d</b>			
0	that the de ed by the a detached	Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. <b>Did</b>		tribute to the cause of death?
<u>α</u>	requiras that the death certifi been signed by the attanding should be detached for use as		end-stage adven Vigleyt	1 🗆	Yes 2 No	3 Probably 4 Unknown
Records,	uiras n sign	d by			en eutopsy	24b. Were eutopsy findings
8	w requir been s should	lete		perfe	ormed?	evallable prior to completion of cause of deeth?
Be	The law ate has b	Completed		1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital		0	25. Wes case referred to medical 26. Piece of Dee			
<b>₹</b>	S 50	To B	exeminer? Hospital: Other:	. /	denca 6 □Othe	r (Specify)
n of	ding Phys h. After this funeral d		27. Menner of Deeth 1 Seturel 5 Pending 28e. Date of Injury (Month, Dey Year) 28b. Time of injury Work? 28c. Injury et Work?	28d. Describe	how injury occurre	ed
Sio	Attending at death. ector: After by the fune	catic	2 Accident investigation M 1 Yes 2 No			
Division	or Attendil aftar death. Director: A I in by tha fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location ( City or To	Street end Numbe wn, Stete)	er or Rural Route Number,
	pital ours a sral D		298. Certifier To Certifying Physician: To the best of my knowledge death occurred at the time, date and place	11.0	43	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, check only one)	red et the ti <i>m</i> e,	date end placa, a	nd due to the cause(s)
	ro the	Me	29b. Signeture end title of certifier 29c. License number		29d. Date signed	(Month, Dey, Year)
			Cutado Ttom W.N MD 1672	5	121	16 99
			30. Name and eddress of person with completed cause of deeth (Item 23e) (Type, Print)	: 1.	110	10-1
			TAN COPSTANG 547-G RIWISOU Vr. SW	-> Ducy	MV	21801
	Sta		31. Dete filed (Month, Day, Year) 33/ Registrar's Signeture			
	Registr	ar	DEC 1 6 1999			



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** GLADYS PHILLIPS December 29 0917 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 27,1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Days Hours Months Country) MARYLAND 214-10-9609 91 Director **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Tes 2 No Directo 28a-f MARYLAND | WICOMICO SALISBURY 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 21804 U.S.A. 306 CAREY AVE. Nerns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: à 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 2 DAVID D. SHORT MARGARET E. **ESHAM** 19e. Informant's Name/Relationship (Type, Print) GRAND 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) sportant: If Item 27 is JENNIFER L. FRIEMAN - DAUGHTER SALISBURY, MD 21804 1503 S. DIVISION ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removel from Stete SALISBURY, MARYLAND PARSONS CEMETERY 1/3/2000 4 ☐ Donation 5 ☐ Other (Specify) 705 E. MAIN ST. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility BOUNDS FUNERAL HOME, INC. 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line. SALISBURY, MD 21804 Approximata Intarval Between Onset and Death **Physician** · Arteriosclerotic Carois VASCULAR disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding n 24 hours after death.

• Funeral Director: Aft
bletely filled in by the lur 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a, Certifier t 🖰 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. conet) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 99 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Dr. Alon DAYIS 3 BISTATE Delmar mo 21875 BIVa

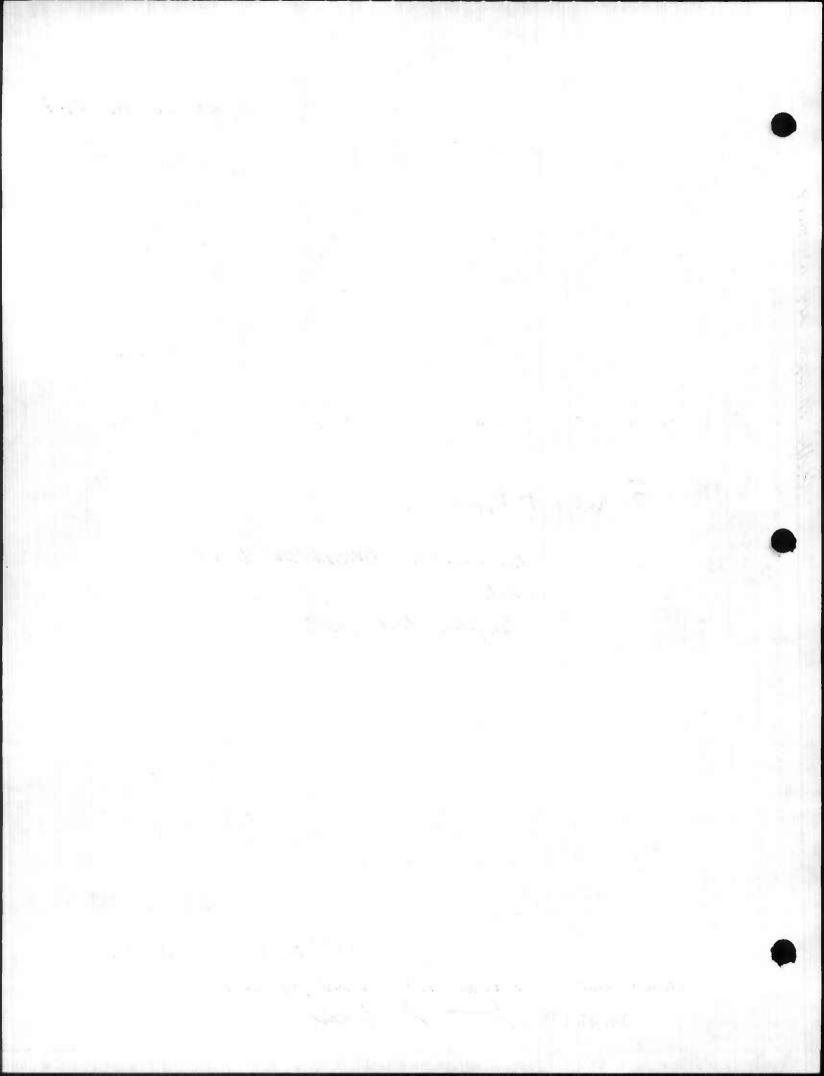
State Registrar

31. Date filed (Month, Dey, Year)

JAN 0 3 2000

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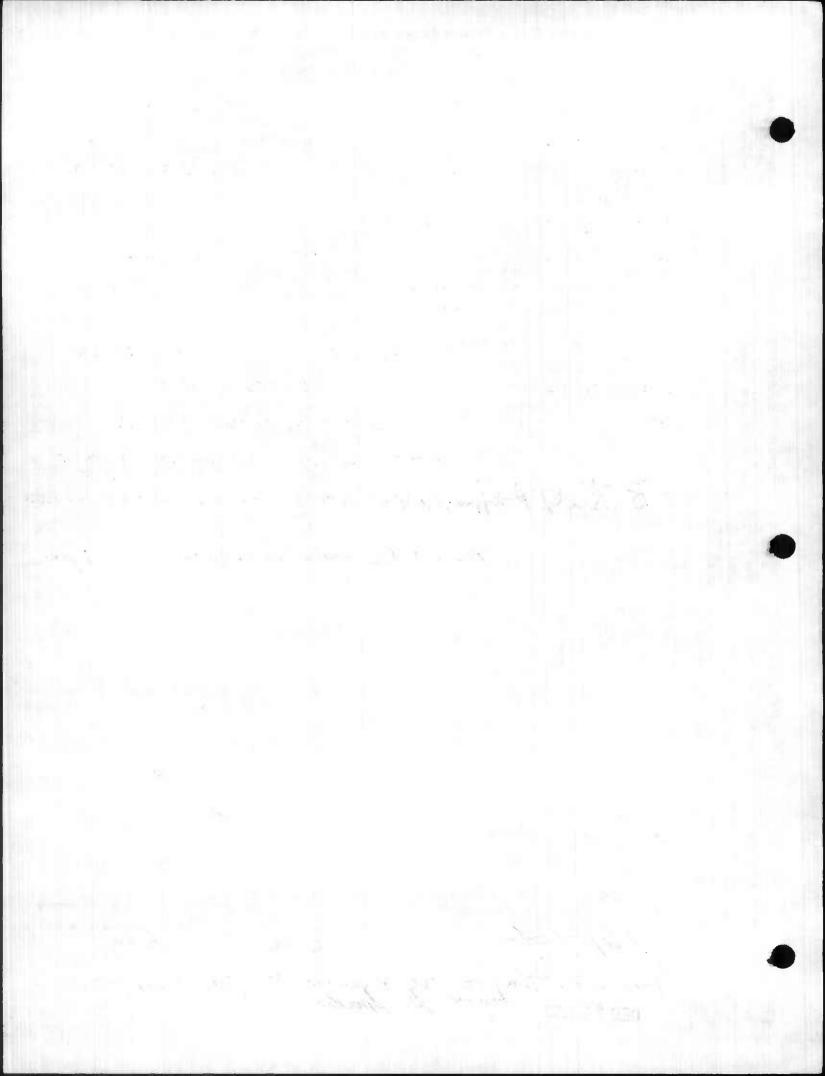
32. Degistrar's Signature



### Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

									of Dear			uel	J. No.		
	1. Decedent's Nar	me (First, Mide	dle, Last)								2. Date of		Day	Year	3. Time of Death
sician edical	JOHN		C.		PRO	VOST,	SR.				DEC.	23	1999	Teal	6:50 PM
miner	4a Facility Name	(If not instituti	ion, give s	street and no	umber)				4b. City,	Town, or	Location of [	eath	4c. County	of Deeth	
	1310 HAM	ILTON	ST.						SAI	ISBU				WICOMI	CO
ral tor	5. Social Security 216-38-7		6. Sex	M 2 F	7. Age (In ) 58			f Under 1 \ Ionths D	Year If Und Days Hour	er 24 Hrs Min	8. Date of Month	Birth Day 1	(ear) 1941	9. Birthplac Country NEW 1	ORK
	Usual Realdence of 10a. State	of Decedent 10b. Count	ty		10c.	City, Towr	n or Location	ion						10d	. Inside City Limi
Director	MARYLANI	WIC	COMIC	0		SAL	ISBU	RY							1 □ Yes 2 □ N
- E	10e. Street and Ne	umber					1	10f. Zip Co				100	g. Citizen of V	1	?
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once.  To Be Completed by Funeral Director	11. Merital Status 1 Never Mar 3 Widowed		arried	Armed F	2 □ No M	ARINE	7	s Decedents, specify	t of Hispenic Cuben, Mexi No Spec		Specify Yes o to Rican, etc	r No-		e - American ck, White, etc WHI'	
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	KAREN E.		721 -	- WIFE					TON ST	SA	LISBU	-	MD 218		Chata
	20a. Method of Dis		3 □R	emoval from		b. Placa of cemeter	y, cremato	ory or othe	r place)		Date		c. Location -	City or Town	i, State
	4 Donation	5 Other (	(Specify)		0	LD MA	RDEL	A CEM	<b>IETERY</b>		12/28/		MARDE 05 E.		RINGS, M
an al	23a. Part1. Enter shock, or he Immediate Cause disease or conditi- resulting in death	(Final	or compli st only or	cations that ne cause on			not enter th	he mode o	FUNER.	as cardia	c or respirate	ory arres	it,	i A	MD 2180 pproximate interval Between chart and Death
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Kobret MAURICE SR Do comber 16, 1999 ation of Death 1138 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) /2 -/2 - 2 / 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 19 M 20 F 78 213-14-6336 Director MALY. INNIA Usuet Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or fleme 23s or 28e-1 snow vant, the Medical Examiner must be nothed at 1 Yes 2 No Director EdRN JOMELS RT ma 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 3830 Funeral PER FREEY 2/822 USA EL 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Armed Forces? [ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: by AMRECIAN 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ount 12 ustod important: If Itam 27 is marked other any injury or other traumatic event, if Baltimore, Maryland 17. Kather's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surgami Pages 1 and 2 should be nent of Health and Mental HEALN B 10 YEALLINE Amas 19e. Informent's Neme/Retationship (Type, Print) 19b. Meiling Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) MADELINE EdRN DOEL Md. 3838 2. a TILL 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, State ry, cr emetory or other 1 ☐ Burial 2 ☐ Cremetion 3 Removei trom State md. **Department** 22 Jd Shi 4 □ Donation 5 □ Other (Specify) RM 22. Name end Address of Fecility 13EPDIE ture of Funeral Service Licenses SALISBURY SABELLE St. runce e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest teilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical tmmediete Cause (Flnat disease or condition resulting in death) **Examiner** Examiner reumonia burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last and Box 68760. Physician/Medical C a SS (8) nse been signed by the atte should be detached for P.O. Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ nknown Records, q Be Completed 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes NANO 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: director. 25. Wes case retarred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deal 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred After Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) within 2 To the 4 29b. Signature and title of cedified 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 16 Rev 6/95

Poik

4390

400

32 Registrer's Signeture

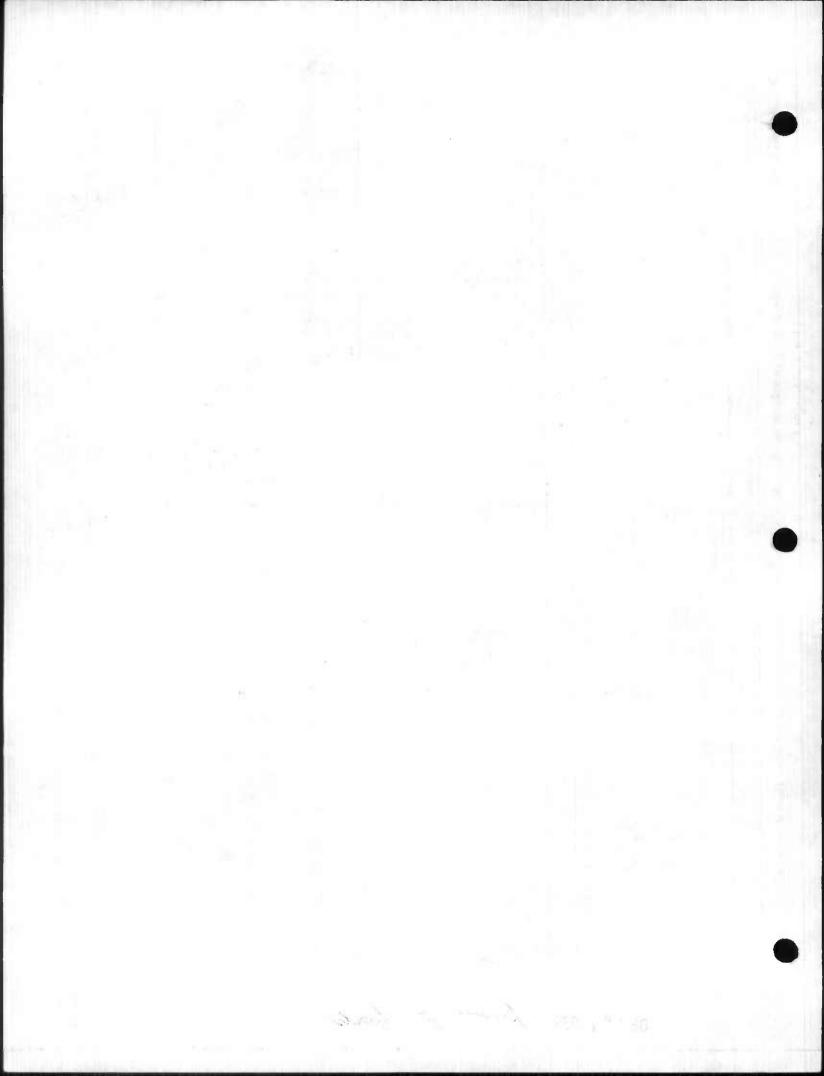
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

10mo

DEC 2 1 1999

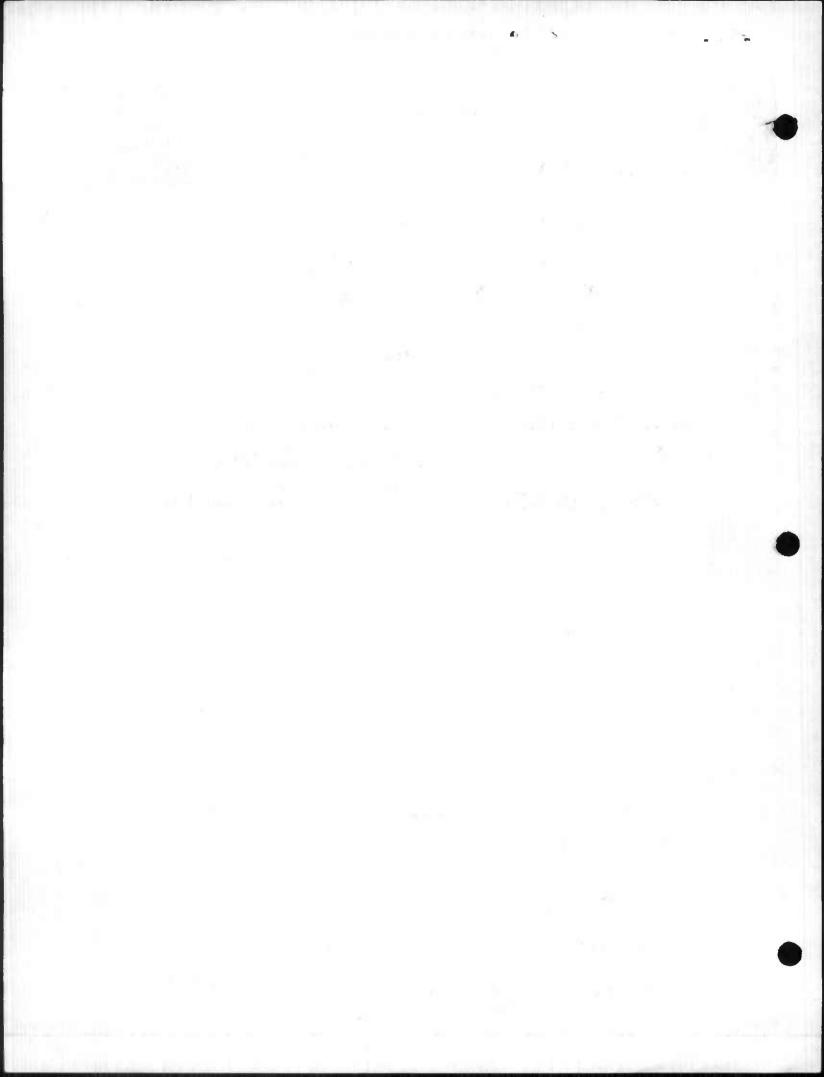
31. Dete tiled (Month, Dey, Year)

D1928



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			Amended #26/12-21-99/W		tate of Maryland / Department of Health and No. /HLC Certificate of Death				Mental Hygiene				
	TO DE LA COLUMN	1. Decedent's Neme (First, Middle, Last)							2. Dete of Deeth			3. Time of Deeth	
Physician /Medical			Shelton Brooks Seldon 3			Jr.			Month Dey Dec. 16 1		Yeer 99	1;05 P	M
	Exami	ner	4e. Fecility Neme (If not Institution, give					4b. City, Town, o	r Location of Deeth	4c. County	of Death		
1_			835 Chippewa B					Salisbu		Wicor	nico		
	Funeral Director		5. Social Security Number 6. Se 218-40-5539	7. Age (In		Yrs. If Under 1 Yeer Months Deys		if Under 24 Hr Hours Mir		Y. Year) 3 1941	Cour	irthplace (State or Foreign Country) crylan d	
	in 72 hours after death with the Maryland "natural", or items 23s or 28s-f show fedical Examiner must be notified at	Director	Usuel Residence of Decedent										
			10a. Stete 10b. County		. City, Tow	n or Location					1	0d. Inside City Li 1 ☐ Yes 2	
			Maryland Wicom	ico	Sali	sbury						1 □ tes 2	INO
		Dir	10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country?										
		To .	835 Chippewa B.	lvd.			2180	1		U.S.A			
21215-0020		by Funeral	11. Maritel Stefus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	<ul> <li>12. Wes Decedent Ever in U,S. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:</li> </ul>		If Yes, sp	<ul> <li>13. Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto</li> <li>1 ☐ Yes</li> <li>2 No</li> <li>Specify:</li> </ul>			Ble	14. Rece - American Indien, Bleck, Whife, etc.  Specify: Black		
			15. Decedent's Edu		16a	Decedent's Us	uel Occur	petion		16b. Kind of B			
		plet	(Specify only highest great	la complated)		(Give kind of v life. DO NOT	vork done	during most of w	orking			,	
213	filed within Hygiene. Ither than "	To Be Completed	Elamantary/Secondary (0-12)	Collega (1-4or 5+)	I	abore				None			
P	d 2 should be filed h and Mental Hygi 7 is marked other traumatic event, it		17. Fether's Nama (First, Middle, Last)					18. Mother's No	ame (First, Middle,		ne)		
lar			Shelton Brooks	Seldon SR.				Reulah	Moore				
Maryland			19a. Informant's Name/Relationship (7)			. Mailing Addre	ss (Street		Rure/ Route Numbe	er, City or Town,	Stete, Zip	Code)	
	CA 00 70 00		Melvin Seldon (1	Brother)		-			Salisbu				
Baltimore,	- 7 5 5		20a. Method of Disposition		W Diana o	Disposition /A	ome of		Dete	20c. Location			
9	0 == 0		1 Burial 2 Cremetion 3 F	Removel from State		ry, cremetory of			12/21/00	0		4.3	
	Departmen Important: any Injury		4 ☐ Donetion 5 ☐ Other (Specify)  21. Signeture of Funerel Servica Licans		rien			Church		Quant	LCO,I	na.	
Ba	permit. F Departm Importan any Injur		21. Significate of Furierer Servica Elicaris	0				ss of Facility Funeral					
_			Blady Bi	Slewart					lisbury,		301		
	Physician /Medical Examiner  23a. ert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or hear feiture. List only one cause on each lina.  Immediata Cause (Final disease or condition resulting in death)  Due to (or es e consequence of):								1000,		Approximate Intervel Between Onset end Deat	th	
	ate be executed hysician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions,	b. Due to (or es e consequança of):									
ů,			Saquantially list conditions, if eny, leading to immadiata causa. Enter Underlying Ceuse (Disease or Injury										
8760,			thef initiated evants resulting In deeth) Lest	Due to (or es a consequence of):									
9	ing p	₹ E								1			
Box	Attending Physician: The law requires that the death certifics or death.  sctor: After this certificate has been signed by the attending ply the funeral director, page 2 should be deteched for use as it.	an	_	v									
0		sic	Pert II. Other significant conditions con	nfributing to death buf not resulting in the underlying cause given in Pert I.			23b. Did t	obacco use co	ntribute to	the cause of de	oth?		
۵.							10	1 1 2 1 os 2 No 3 Probably 4 Unk			.nown		
of Vital Records,		by									T		
		Be Completed								24e. Wes en eutopsy performed?  24b. Were eutopsy fin eveilable prior to			
ec								of deeth?		mpletion of cause daeth?	,		
<b>E</b>									101	res 20 No	1[	☐Yas 2☐ No	
/ita			25. Was case referred to madical examiner?					26. Place of D	eath (Check only o	na)			
5		2	1 Yes 2 No	lospital:	2 2 500	CONTINUENT 3 DOA Othe		nar: 4 Nursing Home 5		Aasidanca 6 □Other (Specify)		y)	
Division o			27. Menner of Death 1 □ Natural 5 □ Panding	28a. Data of Injury (Month, Day Year) 28b. Time of Injury					28d. Describe	28d. Describe how injury occurred			
		ati	2 Accident Invastigation	M 1 Yes 2 No									
i <u>V</u>	To the Hospital or Atland within 24 hours after death To the Funeral Director: / completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide datermined	28e. Placa of Injury - Af homa, farm, streat, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	rai Dellied												
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Cartifiar (Check only (Ch								teted. the causa(s)		
	the the	Med	one)	end manner stated.			On Linear	a mumbar		20d Data siene	d /Manth	Day Vaas	
	0 × 10	-	29b. Signeture end title of cartifier					D 2 9 1 6 8		29d. Date signed (Month, Day, Year)			
			- per al	U, M. D	-		02	7168		1210	167		
	_		30. Neme end eddrass of parson who co	ompleted causa of daeth	(Item 23a)	(Type, Print)				/			
-	5		100 Power	- St.	Sal	Shur	4	mel	. 21	408			
	Sta		31. Dete filed (Month, Dey, Yaer)	32. Registrer's S	igneture	/	1						
	Registr	ar	DET: 2.1 1999		/	400	Ks/						

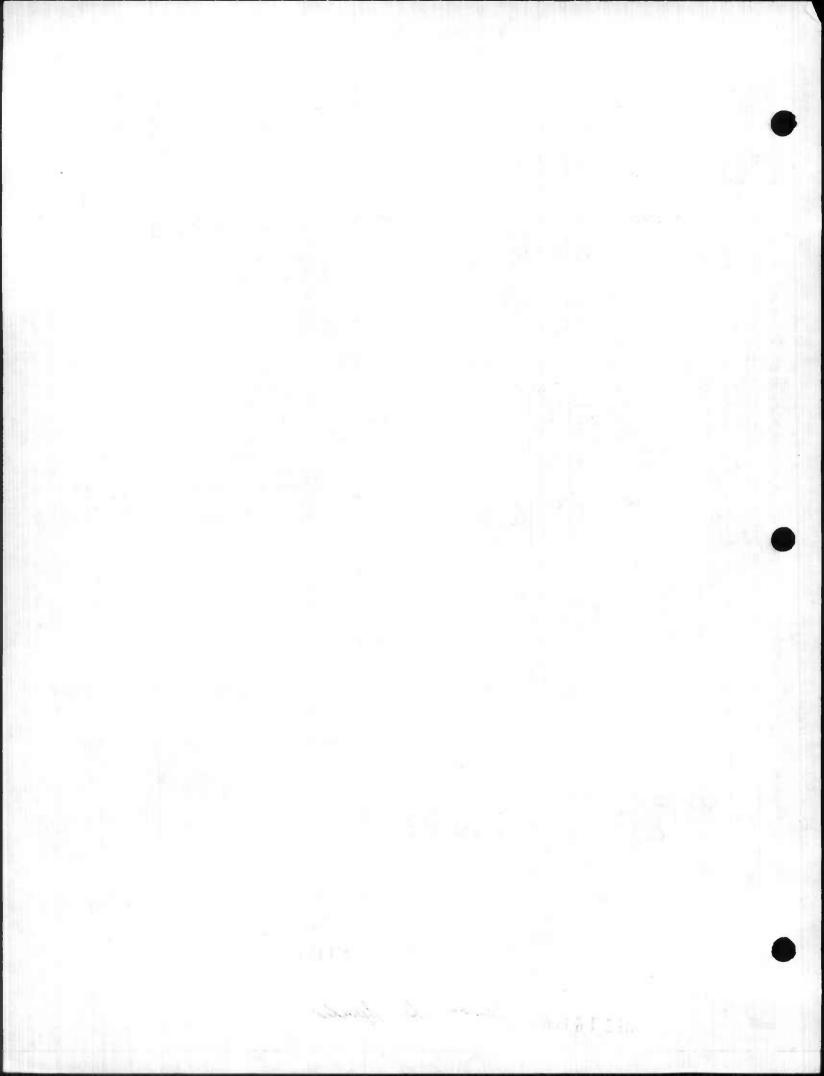


# Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	R	eg. No.	42181		
Physician	Decedent's Neme (First, Middle, Last)						3. Time of Death		
/Medical		RGIS	TILGHMA	7	RECEMBE		99 1218		
Examiner	4e Facility Neme (If not institution, give street and numb PENINSULA REGIONAL MEDI	SALISBUI	RY		Death DMICO				
Funeral Director	5. Social Security Number 6. Sex 1 M 2 T 7.  214-18-4682	Age (In yrs. last birl	thday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 2]		Birthplace (State or Foreign Country) Maryland		
aryland show stat	10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits		
vith the Many or 28a-f sh be notified.	Maryland Wicomico	sa	alisbury				1 ☐ Yes 2 🖾 No		
E 5 E	10e. Street and Number  2712 Merritt Mill Rd.  10f. Zip Code  10g. Citizen of What Country?  USA								
b Fr 6 02	1. Maritel Stetus  1 □ Never Merried 2 □ Merrled 3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No II Yes, Give Year or Detes:		13. Wes Decedent of H If Yes, specify Cubs  1 ☐ Yes 2 ☑ No		cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
od within 72 ho og within 72 ho yglens. Ner than 'naturn's, the Medical, st. the Medical.	15. Decedent's Education (Specify only highest grade completed)	16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)			16b. Kind of Busin	d of Business/Industry		
2121 I within liens. I then the Me	Elementery/Secondery (0-12) College (1-4or 5+)					T-100 - 100			
ind 2 tal Hygi dother event, in	17. Father's Name (First, Middle, Last)		Secretary	18. Mother's Name	(First, Middle, I		rance		
Vlar Wenta Wenta Mise ev To B	Lloyd William Sturgis			Anna El	izabeth	Adams			
Aary 2 sho and le me	19a. Informent's Neme/Retationship (Type, Print)		Mailing Address (Street						
	Daniel A. Tilghman/Son  20a. Method of Disposition		2712 Merritt			oury, MD			
Baltimore,	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from St. 4 ☐ Donetion 5 ☐ Other (Specify)	10	Disposition (Name of y, crematory or other place DO Memorial Par	171		Salisbury			
Deam Popur Importing	21. Signeture of Funeral Service Licensee  22. Name and Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804								
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that cause on each shock, or heart failure. List only one cause on each shock, or heart failure. List only one cause on each shock or heart failure. List only one cause on each shock of the cause of cause or condition resulting in deeth)	ente In	onsequence of):		respiratory em	931,	Approximate Intervet Between Onset and Death		
6876( rifficate be ng physicia as the bu	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in deeth) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
P.O. BOX (that the death certing of by the attending detached for use a Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown			
ecords, aw requires the is been signed 2 should be d					24a. Wes a perform		24b. Were autopsy findings available prior to completion of cause of death?		
= F # 0 0					1 🗆 Y	es 2 No	1 Yes 2 No		
Of Vital I Physician: The this certificate ral director, pages and director, pages and director.	25. Wes case referred to medical examiner?  1 Yes 2 No Hospitel: 1 Plan		testinat all DOA Oth	26. Place of Death			40		
ng Ph her th meral	27. Magner of Death 1 Neturel 5 Pending (Month, 2 Accident Investigation		tpatient 3 DOA Clime of hjury M 1	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
Division or To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Plece of building	Injury - At home, far etc. (Specify)	rm, street, factory, office	1		n (Street and Number or Rural Route Number, Town, State)			
n 24 hospit in 24 houn ne Funera pletely fille	29a. Certifier (Check only one)  1[Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.								
To the common common N	29b. Signeture end title of padylies	waln	29c. Licens	e number	2	9d. Dete signed (	Month, Day, Year)		
3	30. Name end eddress of person who completed cause of			• 3					
State	31. Dete filed (Month, Day, Year) 32. Aleg	Castern St istrar's Signature	y. Sparks	15 bury N	14.				
Registrar	DEC 1 6 1999	eva /	9. sporks	/					

TILGHMAN

DOROTHA



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month DEC. **Physician** 3:00 AM OLIN **JAMES** TARR, SR. 13 /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 605 SCHUMAKER LANE SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Stete or Foraign
Country) 7. Age (In vrs. lest birthdev) **Funeral** Months 1 M 2□ F 220-16-9785 JUNE 5,1924 MARYLAND Director 75 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene.
Intel if Hen 27 is marked other than "natural, or items 23e or 28e-1 show mix! if Hen 27 is marked other than "natural, or items 25e or 28e-1 show into or other traumatic event, its Mendoal Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 605 SCHUMAKER LANE 21804 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No AR If Yes, Give Yaar or Dates: WWII Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. ARMY 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE WWII Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT usa ratired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE CITY OF SALISBURY 17 Father's Name (First Middle I ast) 18. Mother's Nema (First, Middle, Malden Sumeme) Be ERNEST TARR TOWNSEND Μ. CLARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) TARR - WIFE SALISBURY, MD 21804 NAOMI R. 605 SCHUMAKER LANE 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. EASTERN SHORE VA CEM 12/16/99 HURLOCK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 705 E. MAIN ST. 21. Signature of Funeral Service Licenses BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that Jaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceusa on each line. Approximata Interval Between Onset and Deeth **Physician** /Medicai Immediata Cause (Final disease or condition rasulting in death) Examiner Examiner physician and the burief-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? Wel certificata has b lirector, page 2 s 1 ☐ Yes 2 15 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No deeth. Investigation 2 Accident after deeth Director: 6 Could not be detarmined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) in 24 hour.
The Funeral Directors of filled in by 4 Homicida Hospital 24 hours a Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end mannar as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) MO 4 IVA 30. Name and addrass of person who complated cause of deeth (Item 23e) (Type, Print)

81

32 Registrer's Signature

90103

Eastern

Salisbury, MD 21804

Shore Drive

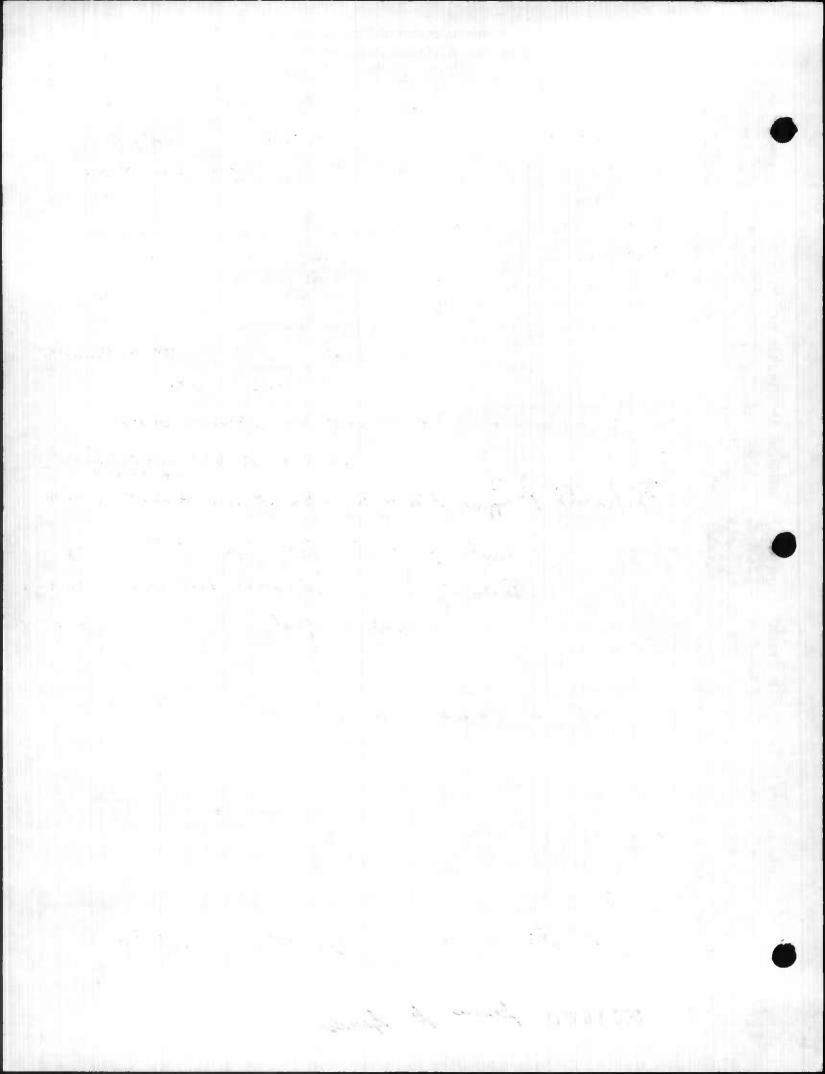
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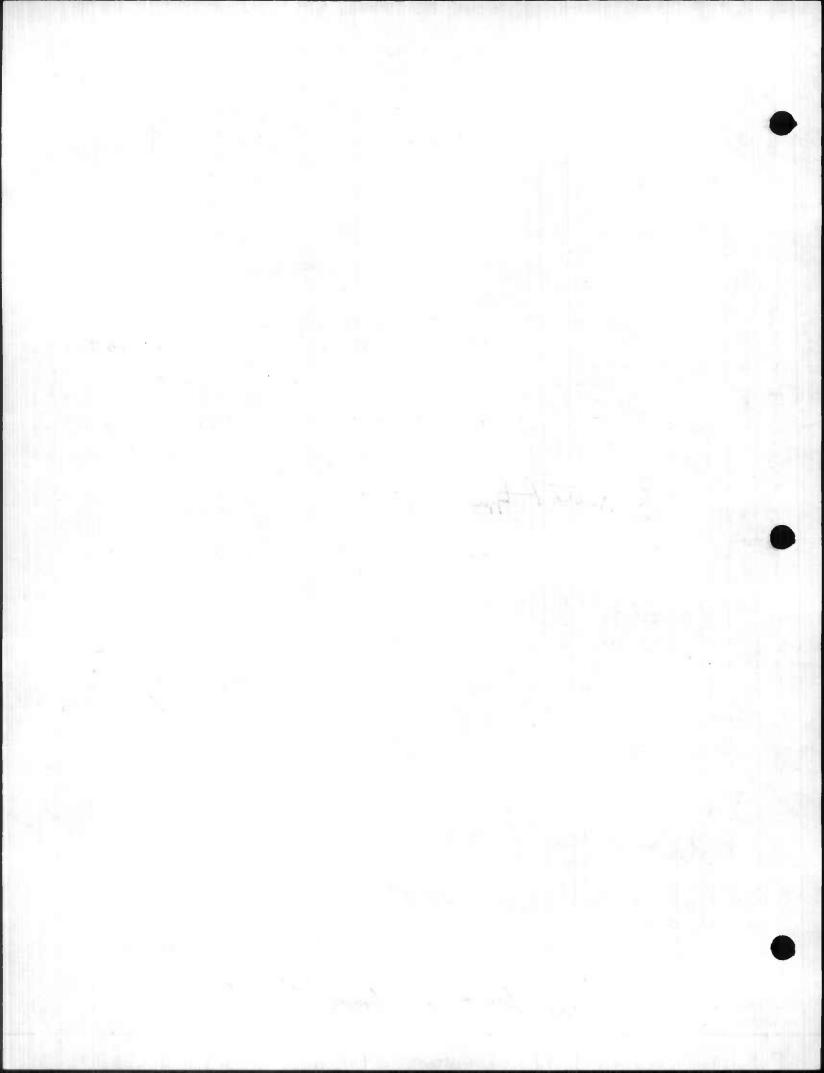
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylan		epartment of F Certificate of		entai Hy	giene Reg. No.99	4278	9
в	Bhuciaian	1. Decedent's Name (First, Middla, Last	)				2. Dete of De Month	eath Day	Yaar	e of Death
	Physician /Medical	George St	evenson	Tho			Dec.	24 199	99 8:15	5 PM
	Examiner					4b. City, Town, or Loc				
_		Salisbury Center;  5. Social Security Number 6. Sa			day) If Undar 1 Yaar	Salisbury		Wico		to as Fassian
	Funeral Director	082-16-1063 Usual Residence of Decedent	7. Age (In yrs. I	Yı	Montha Days	Hours Min.	8. Date of Bi (Month, Di SEPT.	2,1913	9. Birthplace (Ste Country) VIRGINIA	e or Foreign
	Mo m	10a. State 10b. County	10c. City	, Town	or Location				10d. Inside	City Limita
	Many Trah	MARYLAND WICOMICO		SA	LISBURY				1 D Y	es 2 No
	or 28e-f a	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	238 c		EXT.		2	21801		U.S.A		
21215-0020	72 hours after death with the Maryland natural; or items 23s or 28s-f show the Empirer must be notified at side by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar in U, Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Datas:	S.	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	lispanic Origin? (Spean, Mexican, Puerto F Specify:	city Yas or No lican, etc.)	14. Race Black Specify:	- American Indian , White, etc. WHITE	
5-0	ed within 72 hours ygiene "natural", A, tre Medica E. Completed by	15. Decedent's Edu (Specify only highest grad		16a. D	ecedent's Usual Occup	ation		16b. Kind of Bus	iness/Industry	
21		Elementary/Secondary (0-12)	Collega (1-4or 5+)		Giva kind of work done ife. DO NOT use retired		9		2222	
2	filed within Hygiene. ther then ent, the He			MA.	RINE ENGINE				PRODUCTS	<u> </u>
Maryland	San M	17. Father's Name (First, Middle, Last) HARRY H. THOMAS				18. Mother's Name MATILDA		, Me <i>iden Sumeme</i> RUITT	)	
ary		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. N	Mailing Address (Street	and Number or Rural	Route Numb	er, City or Town, S	Stete, Zip Code)	
	rt tr	JOAN M. JENKINS -	DAUGHTER	109	35 HARRY RI	GGIN RD.	PRINC	ESS ANNE	, MD 2185	53
ore	2 7 2	20a. Method of Disposition  1 Burlal 2 Cremation 3 F	20b. P	iaca of D	Disposition (Neme of cremetory or other plea	ca)	Data	20c. Location - 0	City or Town, State	
Ē	Pag int: h	4 Donation 5 Other (Specify)	Tellioval Ilolli State		O MEMORIAL		/29/99	SALISB	URY, MARY	LAND
Baltimore,	permit. Page Department of Important: If eny Injury or page.	21. Signature of Funeral Service Licens	P.P.	FSI	22. Name and Addre		,INC.		AIN ST. Y, MD 218	304
		23a. Part1. Enter the disease, or complishock, or heart tailure. List only of	ications that caused the death	. Do no	t enter the moda of dyir	ng, such as cardiac or	raspiratory a	rrest,	Approxim	nate Between
	Physician								Onset a	nd Death
	/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)	Meumon	no				-5	DAS	
			Due to (or	rasa co	nsequence of):					
	executed in and ial-transit					Denentes	3		1	
,	icate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or	as a co	nsequence of):					
68760,	physicians the buri	Cause (Disease or injury that initiated events	C. Due to for	90 9 000	nsequenca of):					
	T		00 01 000	as a cor	isequerica orj.					
Box	death certifie e ettending   e ettending   ed for use as sician/Me		1							
	0 0 0	Part II. Other algnificant conditions con	ntributing to death but not resu	ilting in t	he underlying cause giv	en in Part I.	23b. Dld	tobacco use con	tributs to the cau	ne of death?
P.0	\$ 50 E						10	Yea 2 No	3 Probably 4	Unknown
18,	8 58 6	2000	V						Oth Mose siden	nu findinan
Records,	The law requir	Remal 1 wants	Meeney					an autopsy ormed?	24b. Were autop available pri completion	ior to
Sec	has by 2 s ye 2 s								of death?	
e	cate ha						10	Yes 2 No	1 ☐ Yes 2	2/2 No
Vital	Physician: The this certificate rai director, page TO Be Co	25. Was case referred to medical axaminer?	Hospital:		Oth	26. Place of Death				
of	Physic rthis carai dire	1 Yes 2 No	1 Inpatient 2 2	ER/Outp 28b. Tin	atient 3LI DOA	Nursing Hor		how injury occurre		
on	th. The After the the	1 Natural 5 Pending investigation	(Month, Day Year)	Inju		k? Yes 2 □ No				
Division	tal or attending P is after death.  In Director: After to led in by the funers  Certification:	3 Sulcide 6 Could not be determined	28e. Placa of Injury - At ho	me, farm	n, street, factory, offica	2		(Street end Numbe	or or Rurel Routa N	lumber,
ā	S affect of in Cert	4   Homicoe	building, efc. (Specify	"			City or 10	wn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: "	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knowner: On the basis of examinate and manner stated.	viedge, d	death occurred at the tire or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the	cause(s) and mar date and piece, a	nner as stated. nd due to the caus	e(s)
	Me other	29b. Signature and title of condition	and market states.		29c. Licans	a number		29d. Date signed	(Month, Dey, Yea	r)
	- 5 - 0	1/////	3		D-398	81.3		17/7	7/99	
		30. Name and address of person who co	ompleted cause of death (Item	23a) /Ts				( -/ -	-//-/	
	5+1VA	MICHAEL ATKINS, M.	D		AY DR., SALI	SRITRY. MD	21804	1		
	State	31. Date filed (Month, Dey, Year)	Registrats Signat		Sporks	ODOME LID.	2100	2		
	Registrar	DEC 2 7 1999	/	,	Mound					



State of Maryland / Department of Health and Mental Hygiene

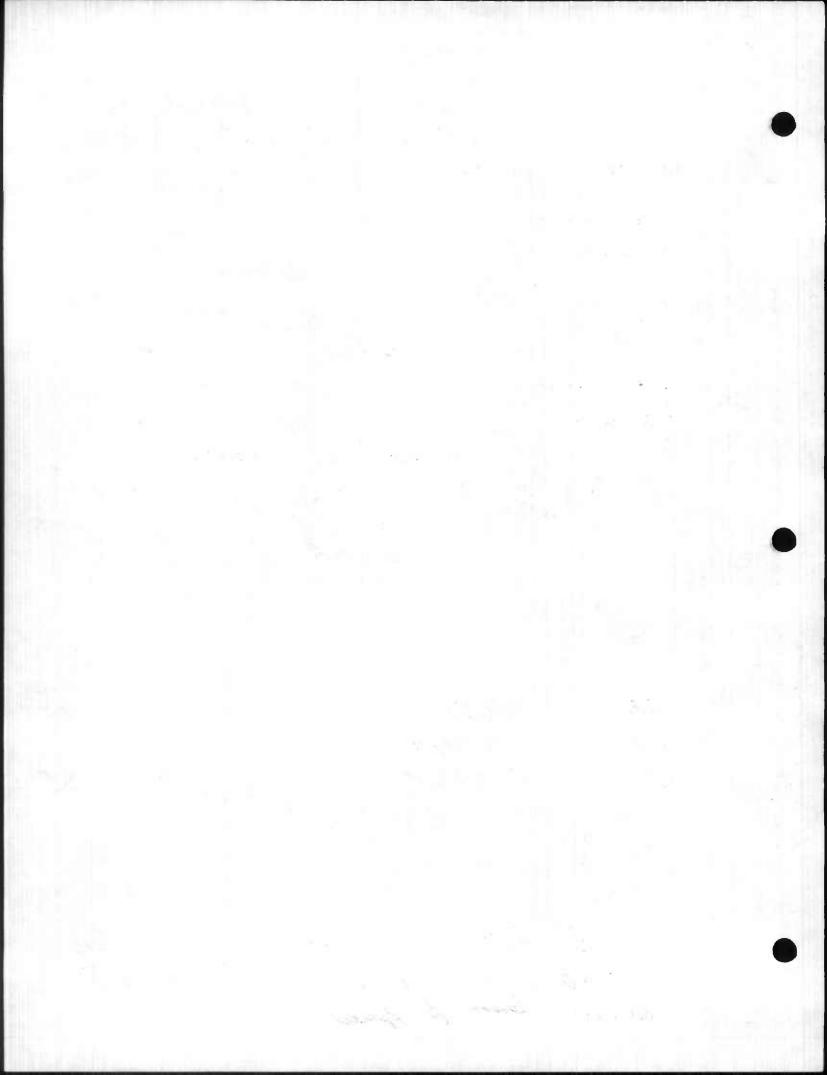
				Certificate of		, ,	eg. No. 99	42790
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deal		3. Tima of Death
	/Medi		Ralph G. Tingle			Dec		99 1:10pm
	Examir	ner	4a. Facility Nama (If not institution, give street and number)		4b. City, Town, or I		4c. County of	
			Deer's Head Center		Satisbu		Wicon	MICO
	Funeral Director		5. Social Security Number  217-07-5883  Usual Residence of Decedent	rrs. last birthday) If Under 1 Ye Months Da		8. Data of Birth (Month, Day, 3/31/1	Year) 9. 907	Birthplace (State or Foreign Country) Maryland
	feryland start	20		City, Town or Location				10d. Inside City Limits 1 ☐ Yas 2 🕱 No
	28a-	Director	MD Wicomico 1	Pittsville 10f. Zip Cod	da.	1	0g. Citizen of Wha	
	with with			2185		1		
	Jeeth 2	Funeral	RFD Tingle Road  11. Marital Status  12. Was Decedent Ever in			pecify Yas or No-		JSA Americen Indian,
21215-0020	filed within 72 hours efter deeth with the Menyland hygiene. ther than "natural", or items 23a or 28s-f show that the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 1 Yes 2 No ff Yes Give Yaar or Datas:	If Yes, specify C	ot Hispanic Origin? (S) Cuban, Maxicen, Puert No Specify:	o Rican, etc.)		White, etc.
0	72 hours natural',	2	15. Decedent's Education	16a. Decedent's Usual Oc	cupation	.00	16b. Kind of Busin	
218	I within 72 ho iene. • than "natur the Med cal	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work do life. DO NOT use re	ne during most of wor tired)	rking		
	or thu	Con	8	owner & carr	penter		general	store
pu	2 2 2	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, I		
yla	should b	2	James H. Tingle		Etha Bel	ll Truitt		
Maryland	CI 0 00 2		19a. Intormant's Name/Relationship (Type, Print)	19b. Mailing Address (Str				
	Heal Heal Her		Richard L. Marshall (nephew)  20a. Method of Disposition	27569 Pember				
Baltimore,			1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cematery, crematory or other	place)	Date	20c. Location - Cit	y or Town, State
표	permit. Peges Department of Important: If II any Injury or o	- 6	4 Donation 5 Other (Specify)  21. Signature Funeral Service Licensee	ine Methodist (	Cemetery []	12/20/99	Whitesvi	lle, MD
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	Physician		23a. Part1. Enter tha disease, or complications that shused the d shock, or haart failure. List only one cause on each line.		,			Intarval Batween Onset and Death
7	/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	ONIU				13daxs
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	tificete be executed g physician end es the burial-transit	хаш		o (or as a consequence ot):			4	saveral
60,	be es ician buria		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	obstructive	pulmona	ry dist	use	years
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	death cert e ettendin d for use	icia	Part II. Other algnificant conditions contributing to death but not	reculting in the underlying course	chien in Part I	23h Did to	hacco use contri	bute to the cause of death?
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ita	delan: The	Be (	25. Was cese reterred to medical examiner?		26. Placa ot Dea	ath (Check only on	(e)	
¥	Physician: rthis certific rral director,	2	Hospital:	ER/Outpatient 3 DOA	Othar: 4 Nursing H	ome 5 Reside	ence 6 Other (	(Specify)
ion	Attending P or death.	ation:	27. Mannar of Death  1 Natural 5 Pending investigation  28a. Date of Injury (Month, Day Year	) Injury \	njuryet Work? I ☐ Yes 2 ☐ No	28d. Describe ho	ow Injury occurred	
Division	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building, atc. (Special Could not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e. Place of Injury - A building not be determined 28e.	t home, tarm, street, tactory, offi ecify)	ca	28t. Location (St City or Town		or Rural Routa Number,
	• Hospi 124 hou • Funer letely fill	edicai	29a. Certifiar (Check only one)  1 Cartifying Phyalcian: To tha best of my leading the deciral Examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the ination and/or Investigation, In m	a time, date and place ny opinion, death occur	, and due to the corred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. Lic	ansa number	2	9d. Date signed (A	Month, Day, Year)
			In a Horard	D	16003		Dec. 19	1, 1999
			30. Name and addrass of person who complated causa of death (I	tam 23a) (Type, Print)				-
	2		INJA J HWANG, M.D	DO BOX 2018,	Salisbu	MY, MD	2180	
	Sta Registr	_	31. Date tiled (Month, Day, Year)  DF C. 2. 0 1999	tam 23a) (Type, Print)  D  BOX 2013  ghatury. Sparses	/			

THE PRODUCTION OF TO LITE

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 00 VIDETTA ULM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ai Haure-de-brace VURSING If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 216-14-2323 Yrs. 94 Director Maryland Usual Residence of Decedent with the Maryland worle 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or flema 23s or 28a-f show treumatic event, the Madical Examiner must be nonfied at 1 ☐ Yes 2 ☑ No Directo Wicomico Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1514 Riverside Dr., Apt. B-303 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or fles any injury or other treumatic avant 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify à 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene F. Dennis Martha Jane Melvin 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel E. Ulm/Son 6775 Levin Dashiell Rd., Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Diaposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremetion 3 □ Removal from State Evergreen Cemetery 12/22/99 Berlin, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Sign 22. Name end Address of Facility m01051 Holloway Funeral Home Professional Association ONLO 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final NEUMON disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner the burial-transit pue Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Diaease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown P 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? has certificate 20 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificial. funeral director, 25. Was casa raferred to medical examiner? Be 28. Place of Death (Check only one) 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 28h Time of Natural 5 Pending 1 Yes 2 No 2 Accidant investigation 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homloida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner station. 29a. Certifier Medical 29b. Signature and title of og of death (Bern 23a) (Type, Print) (Month, Day, Year) State Registrar



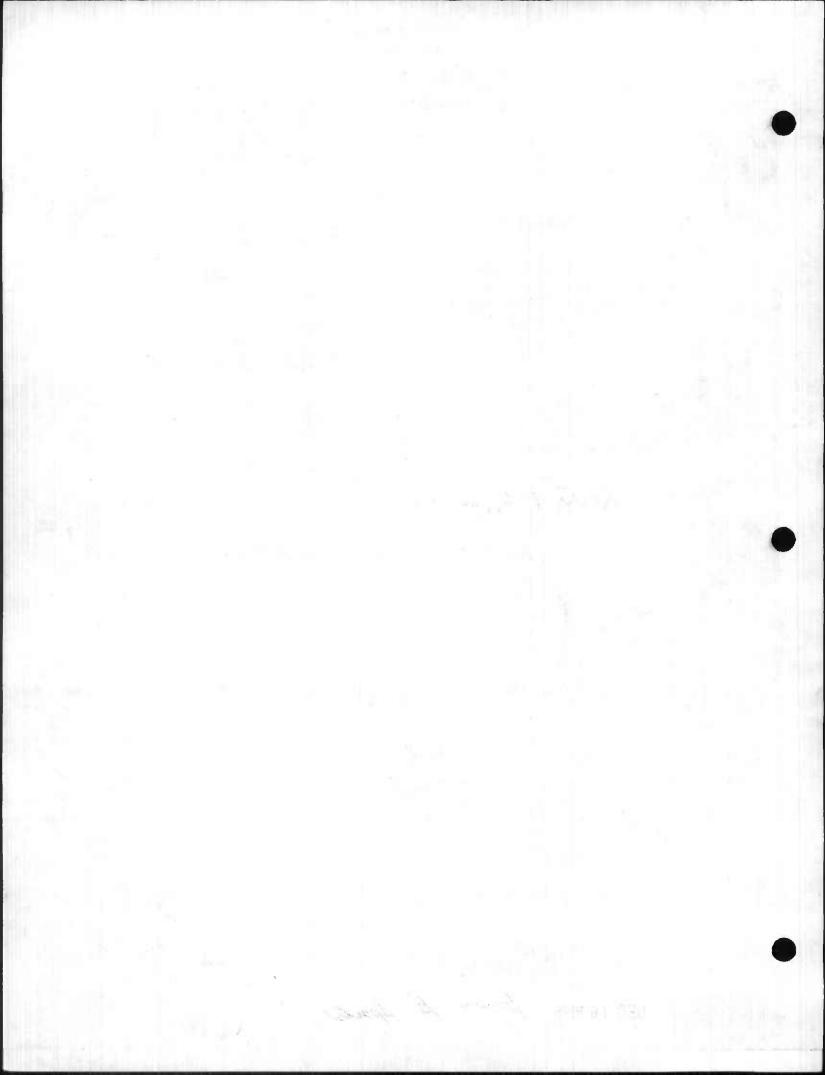
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician V. WILSON ELIZABETZ DECEMBEN 14, 1999 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** Sex 1□M 20 F Months Days 212-18-6936 79 AUG. 2, 1920 Director Usual Residence of Deceden 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND WICOMICO MARDELA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? \*natural", or liams 23s or 25761 OCEAN GATEWAY 21837 U.S.A. 11 Marital Status 12. Wes Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: 2 3 H Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL CAFETERIA 12 COOK and Mental Hygis Is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be sent of Health and Mental KENT DYKES ETHEL. DYKES 19a. tnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: if Iham 27 is any Injury or other trea once. STANFORD L. WILSON - SON 25761 OCEAN GATEWAY MARDELA SPRINGS, MD 21837 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removel from State MARDELA MEMORIAL CEMETERY12/18/99 4 ☐ Donation 5 ☐ Other (Specify) MARDELA SPRINGS, MD 21. Signature of Funeral Service Licensee 705 E. MAIN ST. 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** probable saile MI /Medical Immediate Cause (Finel ONEllow disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use as the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. Geerfield with 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Right TIBIS Franction 24a. Was an autopsy performed? Completed STOWNE 1 Yes 20 No 1 Yes 28 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Watural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/16/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 , RT 50 + EAST CLUKANE Solesing MD MO MATKINS SCGE 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 16 1999

Registrar

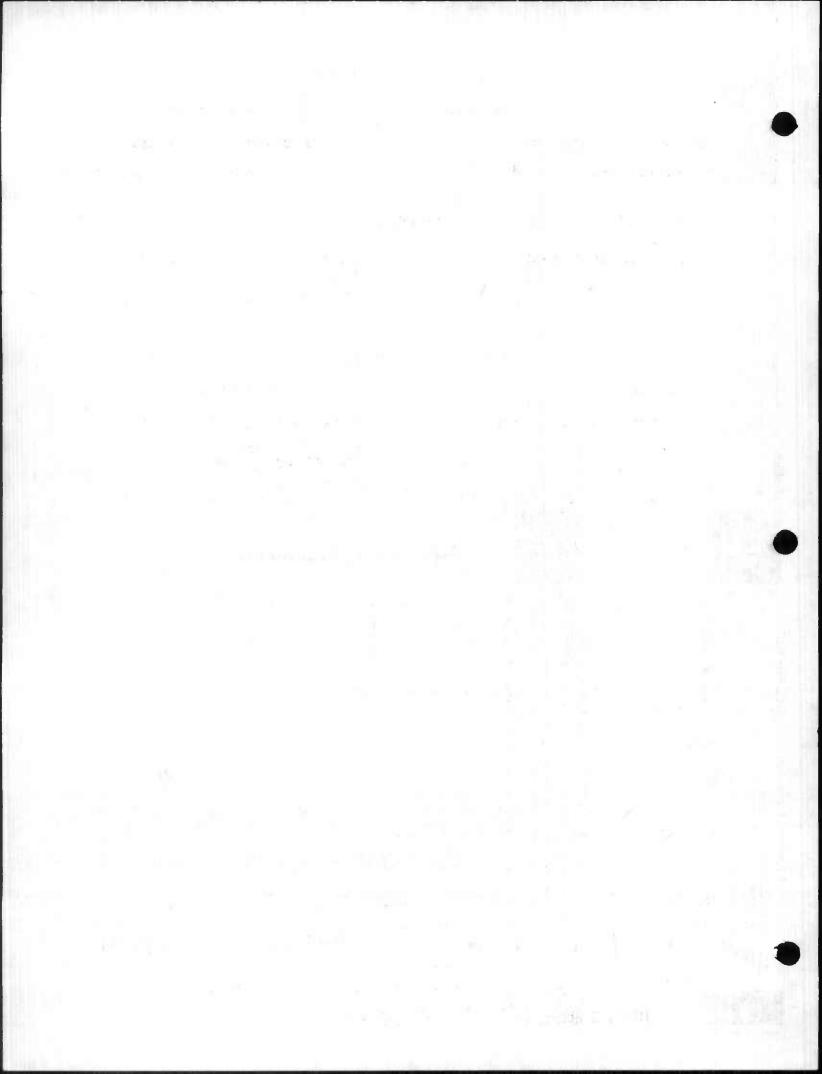
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State of Maryland / Department of Health and Mental Hygiene

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1	Physic /Medi		Mabel	Wat	ers				Dec.21	1999	Year	6:AM
	Exami		4a. Facility Nama (If not institution, giv					4b. City, Town, o	Location of Death			
			Tawes Nursing	Home				Crisfi	eld	Some	erset	
	Funeral Director		213-14-7002	ex 7. Ag	e (In yrs. las 78	t birthday) Yrs.	If Under 1 Year Months Days			n r, Year)		e (State or Foreign and
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	nation				Tana	
	sho	5										Inside City Limits  1 XYes 2 □ No
	the A	Directo	Maryland Somers 10e. Street and Number	et	Ci	risfi						
	with a						10f. Zip Code			10g. Citizan of		,
	s 23	eral	316 Locust Str	eet 12. Was Decedent	From in II C	40.1	2181		2 7 1	U.S.A		
020	d within 72 hours after death with the Maryland ilene. Than "natural", or items 23s or 28s-f show the Medical Exartiret must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?  1  Yes 2   If Yes, Give Year or Dates:			If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	Bla Specif	ck, White, etc.  Slac	
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lan	and I and I s me		19a. Informant's Name/Relationship (1	Type, Print)		19b. Mailir	ng Address (Street	and Numbar or F	Rural Route Numbe	r, City or Town,	State, Zip Co	ide)
2			Jeffery Waters	(Son)	2	7105	Crisf:	ield Ma	rion Rd	.Crisf	ield,	Md.2181
Baltimore,	permit. Pages 1 en Depertment of Heel Important: If Item 2 any injury or other ance.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Plac	e of Dispo etery, crer	esition (Name of matory or other pla sley Cer	ce)	12/27/99	20c. Location	City or Town.	
Balti	Depenting Imports any inju		21. Signature of Funeral Servica Licen	0 1	-	st.	Name and Addre	ess of Facility Funeral	Home			
ú	_		23a. Part1. Enter the disease, or comp shock, or haart failure. List only	Stewas					isbury,			pproximate
	Physician /Medicai Examiner	ner	Immediate Cause (Final disease or condition rasulting In death)	a		piraf	ion f				On	érval Between iset and Death
68760,	rifficate be executed ng physician and as the buriel-transit	Medical Examiner	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting In death) Last	с	Due to (or as	W						
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, P.O.	that the	by Phy							1 🗆 Y		3 Probabl	
Division of Vital Records,	Attending Physician: The law requires that the stroath.  strofash. After this certificate has been signed by th by the funeral director, page 2 should be deteched by the funeral director.	Completed b							24a. Was a perfor		avallat	autopsy findings ble prior to etion of cause th?
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sion	or Attending F after death. Director: After in by the funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Year) 28	b. Time of Injury	Wor	y at rk? Yes 2 □ No	28d. Dascribe ho	ow injury occur	red	
DIV	5 분 분 드	Certifi	4 Homicida determined	28e. Place of injubuilding, efc	ry - At home :. (Specify)	, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rural Ro	ute Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	raiclan: To the best of liner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tir restigation, in my o	ma, data and place plnion, death occ	a, and due to the courrad at the tima, d	ause(s) and ma ata and piace,	inner as stated and dua to the	d. cause(s)
	To the Toom		29b. Signature and title of certifler				29c. Licens		2	9d. Date signe	d (Month, Day,	Year)
-	and		) (Y V	1 +0	7		D	48098		12/	21/99	
	W	-	30. Nama and address of person who c	omplated causa of da	ath (Item 23	a) (Type, f	Print)					
	13		Vijay Karumbuna					riefial	I A M A 21	817		
	Sta	e	31. Date filed (Month, Day, Year)	32 Hegistra	r's Signature				su nu.21	U-1-1-		
	Registra	ar	DEC 23 1999	Brin		y.	Sparker	,				

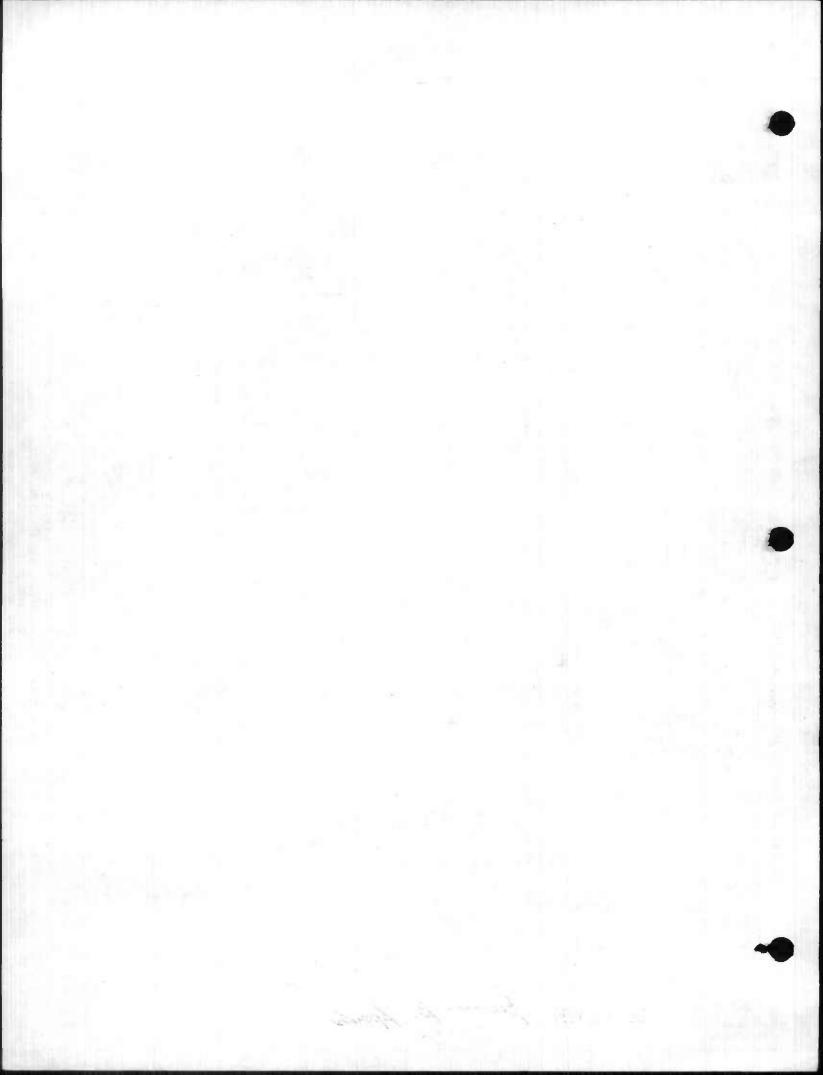
DHMH 16 Rev 6/95



within 2 0

29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 12, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mosphon DISUM 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) 32. Registrer's Signature DEC 2 1 1999 **ORIGINAL** 

State Registrar



State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month **JAMES** WILLEY JR. DEC. 1999 11:15 PM 16 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ESHAM FARM, BACK CREEK ROAD BISHOPVILLE WORCESTER If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys Director 222-24-8285 60 AUG. 18, 1939 DELAWARE Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits The Maryta 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yas 2X No Director MARYLAND WORCESTER BISHOPVILLE 10e. Straat and Number 10f. Zip Code 10g. Citizen of Whet Country? ö Norms 23s 10207 HOTEL ROAD 21813 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yaar or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. filed within 72 hours after 1 Navar Married 2 Marriad b 21215-0020 1 ☐ Yes 2 K No Specify: by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent'a Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) **FARMER** AGRICULTURE 11 Maryland 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be h and Mental 1 should be **JAMES** WILLEY SR. ALICE McGEE 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: if Nem 27 is any injury or other tra-once. DONNA L. WILLEY/WIFE 10207 HOTEL ROAD, BISHOPVILLE, MARYLAND 21813 Baltimore, 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 12/19/99 BISHOPVILLE, MARYLAND BISHOPVILLE CEMETERY 22. Name end Addrass of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 un 23a. Pert1. Enter the disease, or complications that day shock, or haert feilure. List only ona cause on a children in the complex of the com neeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onsat and Deeth **Physician** /Medical Immediate Cause (Final GUNSHOT WOUND disaasa or condition resulting in deeth) HEAD MALDIME Examiner Due to (or es a consequence of). Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate causa. Enter Underlying Cause (Disaase or Injury that initieted events resulting in daeth) Last and Due to (or as a consequence of) Box 68760. physician Physician/Medical the di Due to (or es a consequance of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. ed by the s P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Division of Vital Records. þ 24b. Were eutopsy findinga available prior to Completed 24e. Wes en autopsy performed? been s completion of cause of deeth? has this certificate 1 Yea 28 No 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ RasIdence 6 ☐ Other (Specify) 2 1€Yes 2 No 28e. Dete of Injury (Month, Day Year) funeral Certification: 27. Mannar of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Affer 5 Pending 1 Naturel 1 Yes 2 No investigetion deeth 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide 6 To the Hospital or within 24 hours aft To the Funeral Di completely filled in A Hospital of 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as steted.

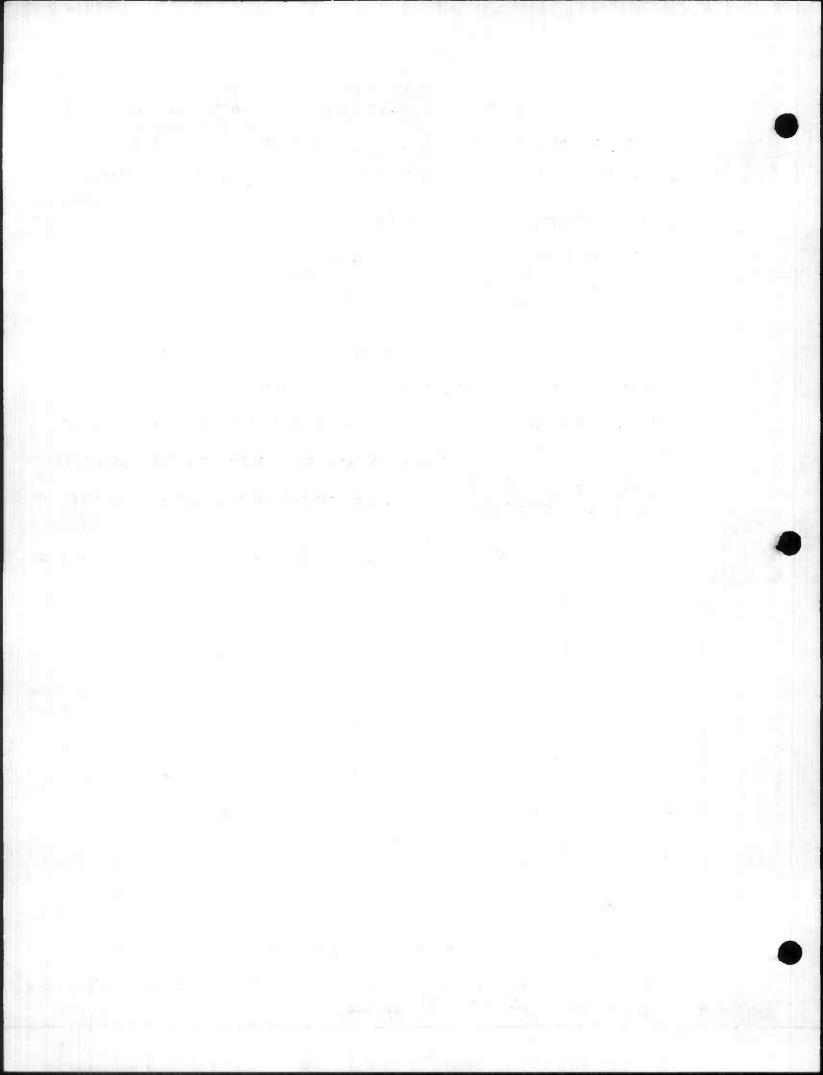
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and pieca, and due to the cause(s) end menner steted. 29e. Cartifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 15 203 SNOW ST SNOW HILL, MD. 21863 HOLZ WORTH DOROTHY

**DHMH 16 Rev 6/95** 

State Registrar

31. Deta filed (Month, Dey, Year) DEC 2 0 1999

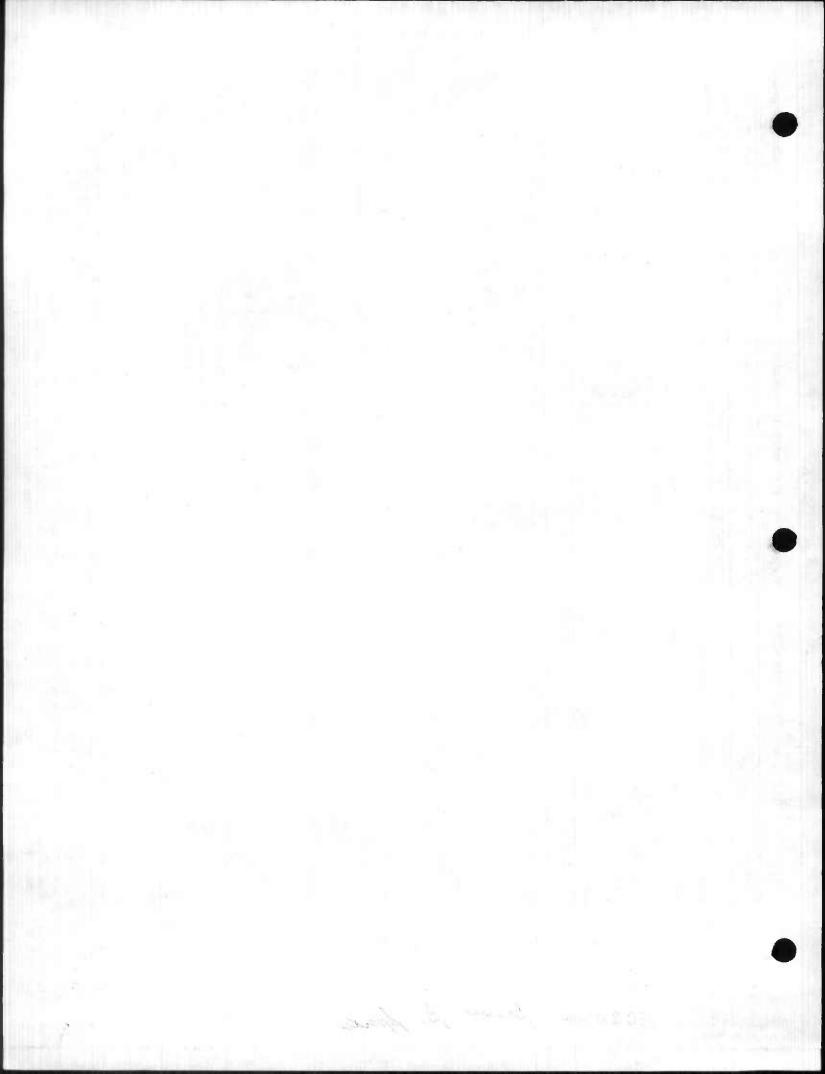
Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Dev Month **Physician** 1220 WALTER MILLER WHITE December 16 /Medical 4e Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 XM 2 F Director 220-32-0624 3/6/1914 Maryland Usual Residence of Decedent works ! 10a. Stete 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2KINO Director Princess Anne MD Somerset 10f. Zip Code 10a, Street and Number 10g Citizen of What Country? 21853 IISA 14015 Cooley Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, Whife, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: If Yes, Give Year or Detes: Navy à 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) retail tire Merchant 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mentel H Important: If Itam 27 is marked oth any Injury or other traumatic avanous. Be Pages 1 end 2 should be nent of Health and Mentel Iris Tull Southey King White 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 14015 Cooley Rd., Princess Anne, MD 21853 Peggy C. White (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Ramovel from Stete Parsons Cemetery 12/18/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Sarvice Licensee 22. Nama end Address of Facility M01051 Holloway Funeral Home, P.A. and Dempoor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete ntervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel Usknose projec Cardaovarialas Assent 9 gears disease or condition resulting in death) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Chionica Obstansfue Palming Breve & Englisen. 1 Yas 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? M. Id Rend Insuffing 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical exeminer?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No Investigation a 24 hours after death Tuneral Director: / oletely filled in by the 2 Accident 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 29e, Cartifiar 12 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and mennar as stated. edicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number 12-16-99 14/02 440 assen 1 10001969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 PINE BLUFFRE Curte 12 SAGISBURY, MO2180 12+1VA Chamesh. CLIFFORD M.D 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar DEC 2 0 1999

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**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

Be Completed by

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

filed within 72 hours after

Pages 1 and 2 should be filed with ment of Health and Mentel Hygiene. mt. If Item 27 la marked other than my or other traumade event, me. It

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altimore, Maryland

8 the page 2 should be To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completaly filled in by the fi

Division of Vital Records,

or Attending Physician:

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25. Wes casa referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2)	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Otl	her (Specify)
27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Data of Injury (Month, Dey Year)	28b. Time of fnjury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, facto	ry, office	28f. Location (Street and Num. City or Town, Stete)	ber or Rural Route Number,
29a. Certifier (Check only one)  1 Certifying Ph	ystclan: To the best of my known ther: On the basts of examine end menner stated.	owledge, deeth occurred etion end/or investigation	d et the time, date and plac n, in my opinion, death occ	e, end due to the cause(s) and m curred at the time, date and place,	anner as stated. and due to the cause(s)
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State Registrar

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31. Date filed (Month, Day, Year) DEC 2 0 1999

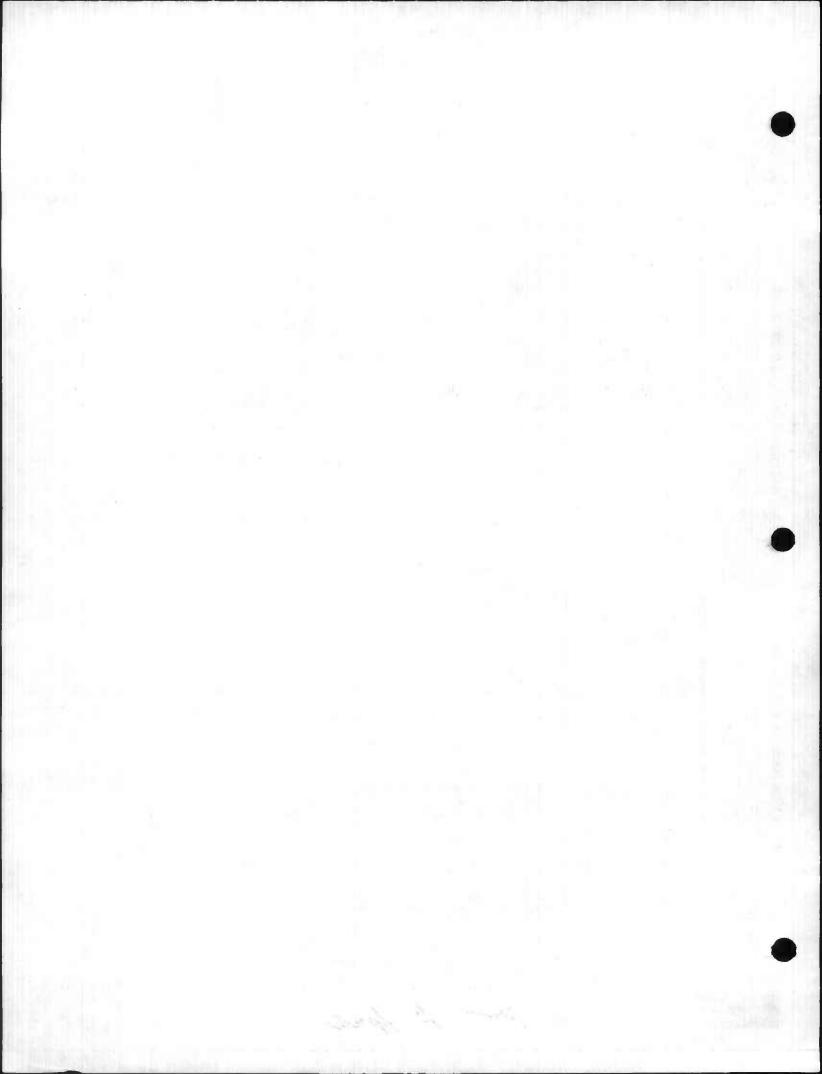
RODNEY

WENRICH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

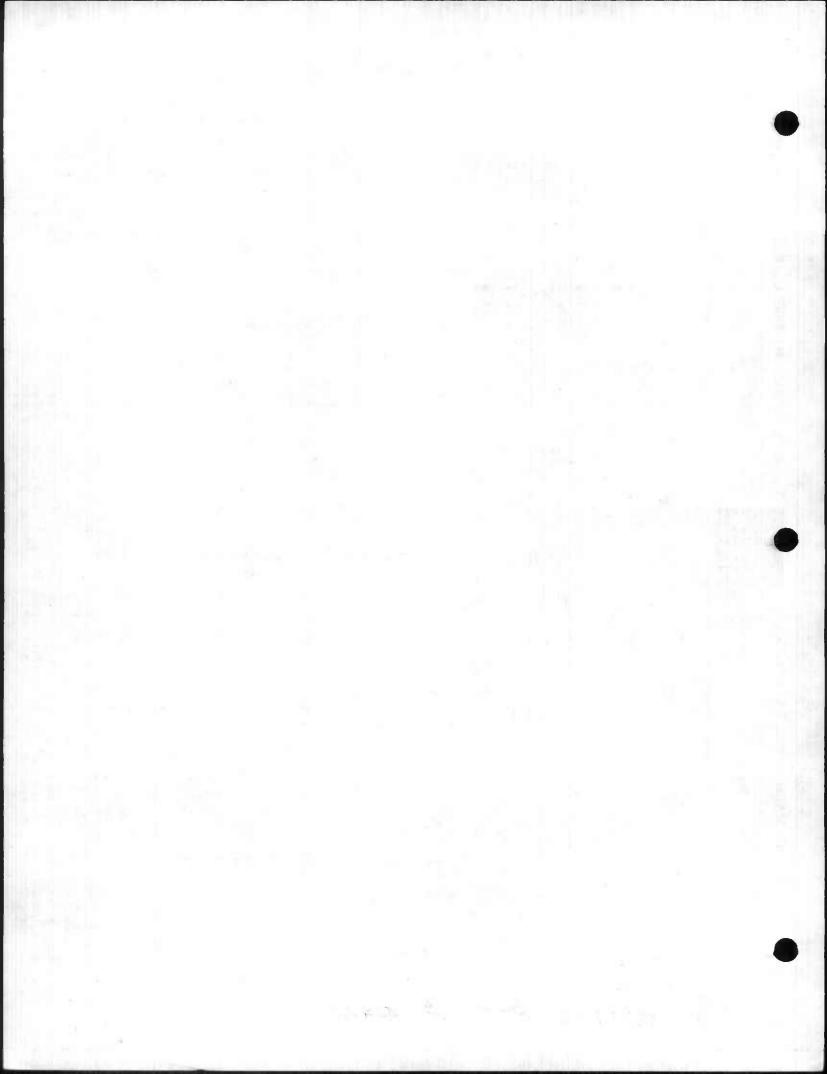
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SALISBURY MD. 2180



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	State of	Maryland /	Department	of Health	and Me	ntal Hygien	9

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al	5. Social Security	y Number 6	5. Sex 1 2 M 2 □		rs. last birthday)	Months Days			irth av. Year)	9. Birthplace (S Country)	tate or Foreign
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	10a. Stata	10b. County		10c.	City, Town or Lo	ocation				10d. Insi	da City Limits
pol	Maryla	nd Wicom	nico			Delma	r			1 🗆	Yas 2 No
Director	10e. Street and					10f. Zip Code	-		10g. Citizen of	What Country?	
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by		arried 2☐ Married	d 1 Yas,	95 2 No		1□ Yas 2N No		to moun, atc.)	Specify		e
Completed	10.	15. Decedent'a	Education	a of l	16a. Dece	dent's Usual Occu	pation	dian	16b. Kind of B	usiness/Industry	
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State of Maryland / Department of Health and Mental Hygiene Q 1. 27 Q Q

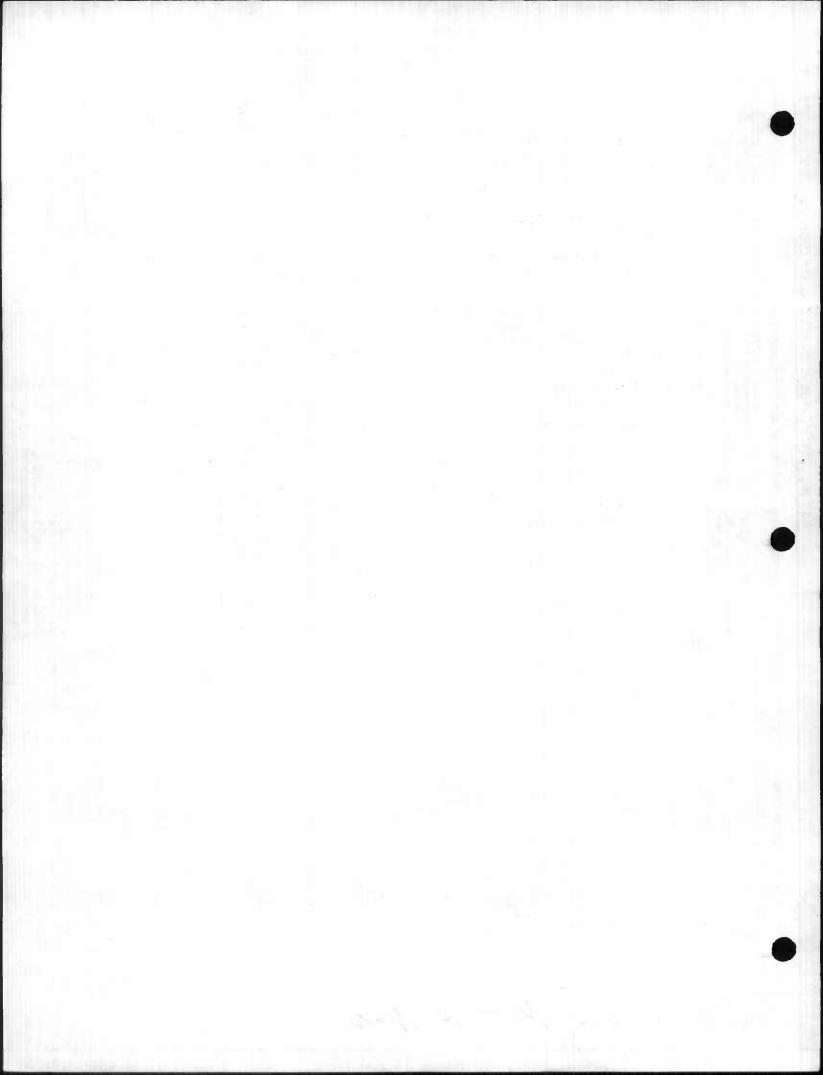
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to	MD	Wicom	ico	D	elmar							1 <b>Y</b> es 2 □
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Bec	17. Father's Neme (First, Mid	idle, Last)					1	8. Mother's Na	me (First, Middle	Maiden Suma	me)	
10 B	William C.	Yates						Ora I.	Burche	tt Yate	S	
	19e, Informant's Neme/Relet	tionship (Ty	rpe, Print)		19b. Meitid	ng Address	Street an	d Number or R	ural Route Numb	er, City or Tow	n, State, Zip	Code)
	Shirley Yate	es/Wi	fe		204	E. Eli	zabe	th Stre	eet De	lmar, M	D 218	875
	20a. Method of Disposition				Plece of Dispo	sition (Name	e of		Date	20c. Location		
	1 ☑ Buriel 2 ☐ Cremet 4 ☐ Donetion 5 ☐ Othe			Stete				1	2-23-99	Norro	le Mar	mrland
1	21. Signeture of Funerel Sen			Л	wen Ce	2. Name and			12-23-33	Newal	K, Fla	ryland
	23e. Pert1. Enter the disees shock, or heart teiture.	e, or compli List only or	icetions that can a cause on a	aused the one	1	3 E. C	rove		elmar,		40	Approximete Interval Between Onset and Death
ner	Immediate Cause (Final disease or condition resulting In death)			gue to (	or as a consec	Hec- quence of):	+	tarto	ere		1	
-					I LINK.	1.1					1	
/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last		I	scher	or es a consequence or es a consequence	HOCH	1	Disec	R.		1 0 0	
edical	thet initiated events	l.		Due to (c	or es a conseq	HOC v	1 use given	D1580	23b. Did	tobacco usa c	ontribute to	o the cause of de
Physician/Medical	resulting in death) Last	l.		Due to (c	or es a conseq	HOC v	use given	D158C				o the cause of dec bebly 4 2 Unkr
by Physician/Medical	resulting in death) Last	l.		Due to (c	or es a conseq	HOC v	use given	D158C	1 🗆 24a. Was		3 Prol	
by Physician/Medical	resulting in death) Last	l.		Due to (c	or es a conseq	HOC v	use given	D158C	1 🗆 24a. Was	Yes 2 No an autopsy med?	3 Prol	bably 4 Unkr ere autopsy finding allable prior to impletion of cause
e Completed by Physician/Medical	Pert It. Other algnificant con  25. Wes case reterred to mee	ditions con		Due to (c	or es a conseq	HOC v			1 ☐ 24a. Was perfo	Yes 2 No an autopsy med?  Yes 2 No	3 Prol	ere autopsy findinaliable prior to mpletion of cause death?
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ledical Certification: 10 Be Completed by Physician/Medical	25. Wes case reterred to medexaminer?  1 Yes 2 Alo 27. Menner of Death 1 Meturel 5 Pe 2 Accident inv 3 Suicide 6 Co 4 Homicide  29a. Certifier Check only 2 Medit	dical honoring restigation but and to be termined withing Physical Examin	dospitet: 1 1 28a. Dete c (Monti	Due to (control of this parties of examine sis of e	sulting in the u  BENOutpatier  28b. Tima or Injury  ome, ferm, str	inderlying cannot be set of the s	Other: c. Injury e Work? 1  Ye office	16. Place of De  4 Nursing I  t s 2 No  date and placeion, death occumber	24a. Was perfo	Yes 2 □ No an autopsy med?  Yes 2 □ No one) dence 6 □ O how injury occu street and Num wn, State)	3 Prol  24b. W. av. oo of  1 [  ther (Specification of Rural manner as sign, and due to	bebly 4 Unkr ere autopsy findin silable prior to mpletion of cause death?  Yes 2 No  y)  Al Route Number, lated. the cause(s)
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DHMH 16 Rev 6/95

Henry yate 55# 214-36-85 39

Baltimore, Maryland 21215-0020

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

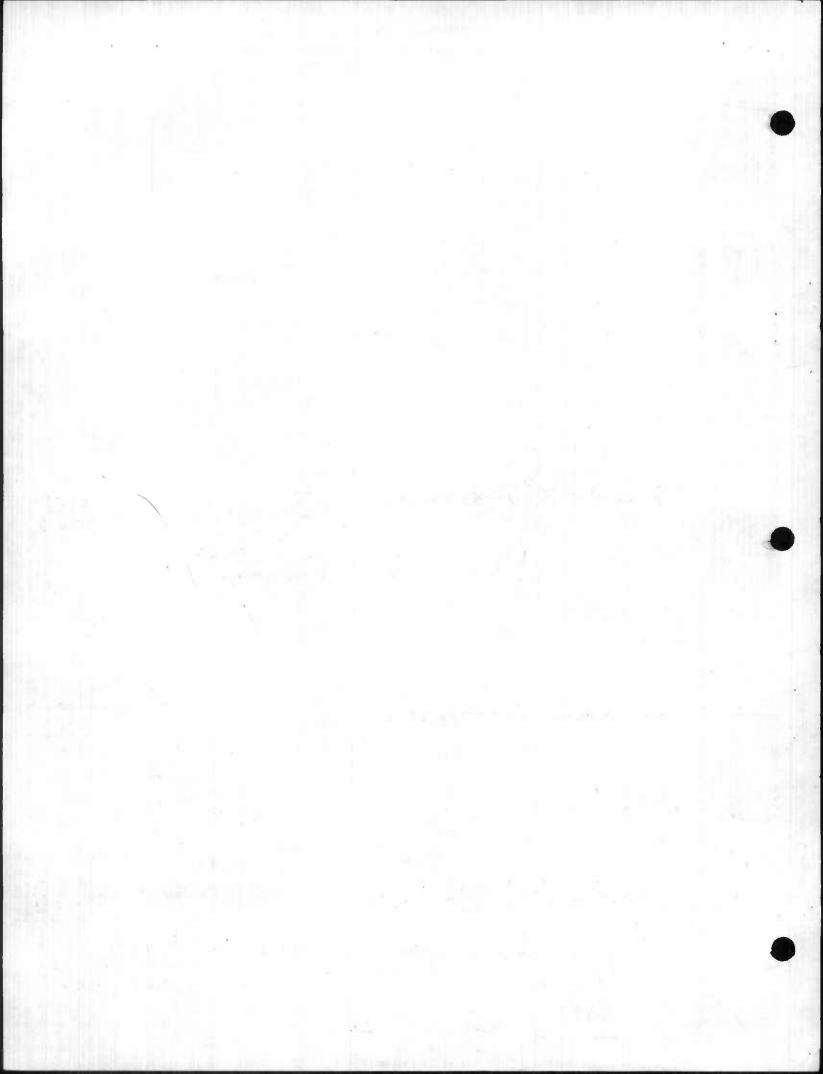


State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle, Last)	2. Dete of Dea		1 2 8 10 Coath
Physician	MAGUY Therese ABU-TAHA	Month NOVEMBE	R 21, 19	99 10:50 A
/Medical		or Location of Death		
Examiner	100 Harrison Ct. Free	derick	Fre	derick
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 6. Sex North Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 F 6. Sex North Age (In yrs. last birthday) Months Deys Hours N	Irs. 8. Dete of Birth (Month, Day May 16		Birthplace (State or Foreign Country) France
	Usuel Residence of Decedent	11-11-1		
de de	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits You Yes 2 No
octo	Md. Frederick Frederick			
or 28s-f s be notified Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	it Country?
1 234 Frai	100 Harrison Ct. 21702			S.A
Is marked other than "natural", or fame 23s or 28s-1 show reumatic avant, the Maddall Examinar must be northed at To Be Completed by Funeral Director	11. Meritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Sive Year or Detes:  13. Wes Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put Yes, Give Year or Detes:	(Specify Yes or No- lerto Rican, etc.)	Specify:	American Indien, White, etc. White
r, the Medical is Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuel Occupation (Give kind of work done during most of the complete of the c	working	16b. Kind of Busin	ess/Industry
other traumatic avant, tra Mar.  To Be Comple	Elementery/Secondary (0-12) College (1-4or 5+)	NO. KING		
LOO CO	12 Hair Dresser		Beauty	Salon
Be		Neme (First, Middle, i	Maiden Sumame)	
0	Amor Jean Mehiz Franc	coise Eug	genie B	ourgne
	19a. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number of			ite, Zip Code)
	Patrick Y. Coajou (Son) 100 Harrison Ct. F	rederic	k,Md. 2	1702
any injury or other ti once.	20e. Method of Disposition  1 Burial 2X Cremetion 3 Remove from State  20b. Plece of Disposition (Name of cemetery, crematory or other place)  Smithsburg Crematory	Nov. 23,1999	20c. Location - Cit Smiths	y or Town, State burg, Md.
BUCE.	21. Signature of Facility  22. Name and Address of Facility  Davis Funeral	Home Sm	525 Brad	dbury Ave.
	23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximete Intervel Between
sian/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  e. Squahous ADENO-Carcinoha  Due to (or as a consequence of): EMETA  Due to (or es a consequence of):  if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or es a consequence of):			
Physician/M	Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			bute to the cause of dear
	Chronic pulmonary Emphysema	1 Y	es 2 No 3	□ Probably 4 🖰 Unkno
Completed by PI		24e. Was a perfor		24b. Were eutopsy finding available prior to completion of cause of death?
E		1 🗆 Y	es 20No	1 ☐ Yes 2 ☐ No
BeC	25. Was case referred to medical 26 Place of I	Deeth (Check only or		
0	examiner? Hospital:	g Home 5 Reside		(Specify)
certification: To Be Com	27. Menner of Deeth  1 Neturel 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No		ow injury occurred	(openly)
Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	281. Location (S City or Town		or Rural Route Number,
edical	29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place of the basis of examinetion and/or investigation, in my opinion, deeth or and menner steted.			
Medical Certification:	29b. Signeture and title of certifier  Genzy 1. Smith M.D. VIMA D 1058		29d. Dete signed (/	
	Gener Smith M.D. VITA D 1058°  30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Horpice FR  GEOLEGE 1. Shittly, M.D. Vice INE AFFAIR FI  21. Detailed Month Day York	EDERICA M	LANYLAN	21701
State gistrar	31. Date filed (Month, Day, Year)  JAN 2 7 2000  32. Registrer's Signeture  Server  G  Aparks			

DHMH 16 Rev 6/95

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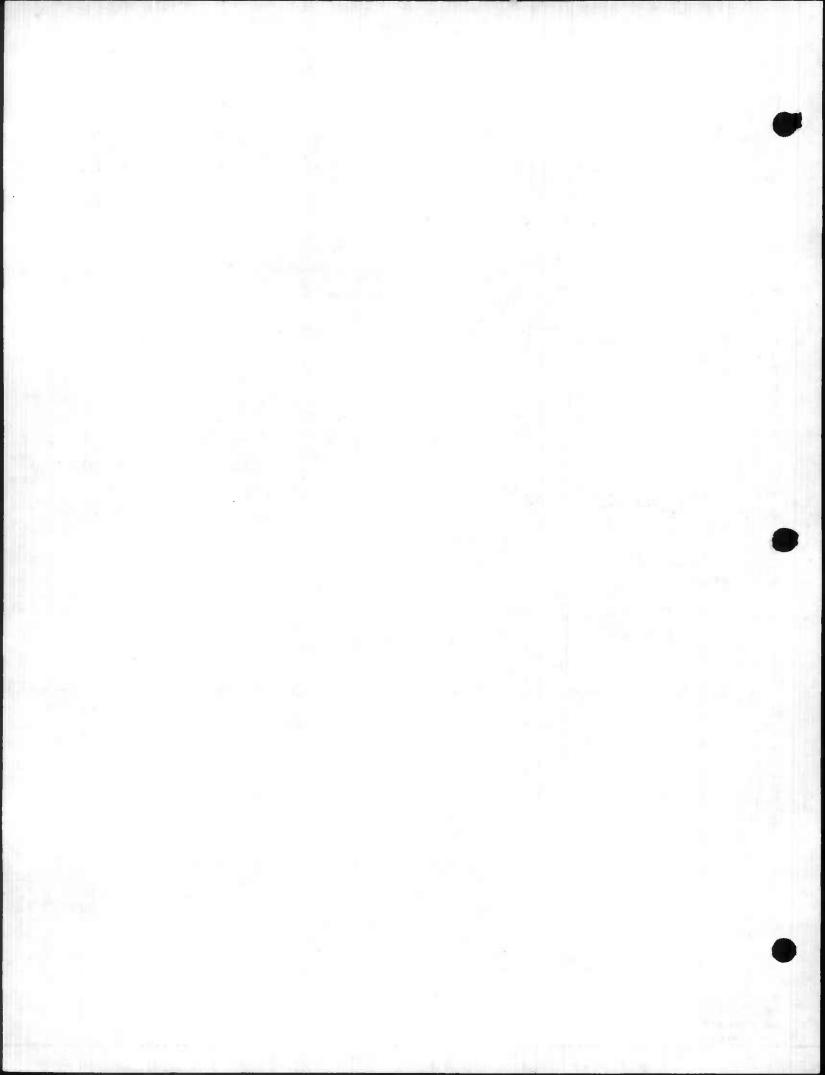
				State of Mary		Certifica					9 4	2801
	Shootal		1. Decedent's Neme (First, Middle, Last	)					2. Dete of De	eth		3. Time of Death
	Physici /Medio		THOMAS	Edward		Bern			Decemb		9 \$ \$ \$	16:53PM
	Examir	er	4e. Fecility Name (If not institution, give John Hopkins					4b. City, Town, or Baltimo		h 4c. County	of Deeth	
	Funeral Director		5. Sociel Security Number 348-32-8319 6. Se	7. Age (Ir	yrs. lest birt	hday) If Und Month	der 1 Year s Deys	If Under 24 Hrs Hours Min	8. Dete of Bir	th 19, 1940	9. Birthplec	ce (Stete or Foreign
	pue M.		Usuel Residence of Decedent  10e. Stete 10b. County	10	c. City, Town	or Location					10d	. Inside City Limits
	Mary H sh	tor	MD			0cean	City					1 Yes 2 No
	h with the 23a or 28a	al Director	10e. Street end Number 14101 Dukes Lane	-		10f. 2	Zip Code	1842		10g. Citizen of V	Whet Country	?
120	n 72 hours after death with the Maryland "natural", or items 23s or 28s-1 show pulcal Examinet must be notified at	by Funeral	11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 XDivorcad	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:1 9 5	in U,S.		cedent of Hoseify Cube	lispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rec Blac Specify	e - American ck, White, etc	
2-00	n 72 hou "natura	ted l	15. Decedent's Edu	cation		Decedent's Us	suel Occup	etlon	42-	16b. Kind of Bu		
Maryland 21215-0020	iene. than the Ma	Completed	(Specify only highest grad	College (1-4or 5+)	S	ife. DO NOT	use retired	•	rking	U	S Gov'	t
and	be filed ntal Hygi of other event, to	To Be	17. Father's Neme (First, Middle, Last) Thomas Wayne Ben	rv					me (First, Middle,		(0)	
iz Z	should od Mei marki	Į.	19e. Informent's Neme/Reletionship (T)		19b.	Mailing Addre	es (Street	end Number or R			State Zin Co	nde)
	alth ar 27 is or trau		Thomas Wayne Ber					n Meadow				20187
altimore,	pernit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, anse.		20e. Method of Disposition 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ F		cameter	Disposition (A	r other pled		Dete	20c. Location -		
Itim	artmen sytant: Injury		4 Donetion 5 Other (Special)  21. Signature of Superal Service License		Ever	ly CRe			12/28/9		andria	, VA
Ba	Deme Impo		1 /2 V/2	Mul			150	19 Willeat 00 W Brac	ldock Rd	. Alex.		2302
	Physician		23a. Pert1. Enter the disease, or comp shock, or heert failure. List only or	that caused the caused the cause on each line.	deeth. Do n	ot enter the m	ode of dyin	ng, such es cardia	c or respiretory e	rrest,	A; In	pproximete itervel Between inset end Deeth
	Physician /Medical Examiner		Immediate Cause (Fine) disease or condition resulting in death)	. VIRAL								WEEK
	D 25	ner				onsequenca o	,	ONE MARI	ROW TRAN	SPLANT	3	MONTHS
,	ficate be executed physician and is the bunal-transit	edical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due CYTOMEG		onsequenca o		ī	_		2	MONTHS
68760,			resulting In deeth) Lest	ACUTE M		onsequence of ENOUS L		1IA			1	YEAR
Вох	thet the death certif ed by the attending deteched for use a	Physician/M				-						
P.O.	the de	yslo	Pert II. Other significant conditions cor	tributing to death but no	ot resulting In	the underlying	g cause giv	en in Pert I.		**		ne cause of death?
		by Pt					-		10	Yss 2 No	3 ☐ Probab	oly 4 Unknown
Vital Records,	law requires thetes been signed to should be detected to should be	Completed t								en eutopsy ormed?	avalla	eutopsy findings able prior to eletion of cause ath?
<u>~</u>	The ate h	Com							1130	Yes 2□No	1 🗆 Y	es 🛍 No
Vita	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	lospitel;			Oth	er.	eth (Check only o			
ou of	5 00	tlon: To	27. Menner of Deeth 1 Netural 5 Pending	28e. Dete of Injury (Month, Dey Ye	2□ ER/Out 28b. Ti ar) in	,	28c. Injur	4 U Nursing F	dome 5 Resident	dence 6 Oth		
Division of	or Attendation of Att	Certification:	2 Accident 3 Suicide 4 Homicide  Investigation Could not be determined	28e. Pleca of Injury - building, etc. (S	At home, fer			763 20140	28f. Location ( City or To	Street and Numb wn, State)	er or Rural R	oute Number,
	To the Hospital within 24 hours and the Funeral completely filled	edical C	29e. Certifier (Check only one) 1 ☐ Certifying Physical Examination (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	iclen: To the best of my ner: On the basis of exe end manner steted.	/ knowledge, minetion end	deeth occurre Vor Investigation	d et the tin on, In my o	ne, dete end pleca pinion, deeth occu	a, end due to the urred et the time,	cause(s) end ma dete end placa,	nner as state and due to the	e ceuse(s)
	within 2 To the comple	Mec	29b. Signature end title of cartifier	ond manner steled.		2	9c. Licens	e number		29d. Dete signe	d (Month, Day	y, Year)
			Dahul gay	MO			RE	5-000		DECEMBE	R 25,	1999
1	MV		30. Name and address of person who co		(Item 23e) (7	Type, Print)		BALTIA				
	Sta Registr		31. Dete filed (Month, Pay, Year) JAN 2 1 2	32. Registrar's S		B	Loon	Kni	,			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 4 2802

		ma (First, Middla, Las Marie Char							2. Dete of De Month		OOYeer	1	of Death	
nysician Medical	-							th City Town o	November Location of Death			11:50	J AM	
xaminer	Prince (	(If not institution, give George Con	m. Hospit	al				Cheverly			ity of Deeth Ce Ge			
neral ector	5. Social Security 262–56–2 Usuel Residence	2243	ex	ge (In yrs. 89	last birthdey) Yrs.	If Under Months	Deys	If Under 24 Hr Hours Mir		1910	9. Birth Cair	piaca (State ntry) O, Ga.	or Foreig	
u	10a. Stete	10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside	City Limit	
ctor	Maryland	Prince G	George	Mito	chellvi	lle						1 X Ye	s 2 N	
iner must be notified at funeral Director	10e. Street and N	ake Front	Ct.				721			10g. Citizen o				
by		rried 2 Married	12. Was Decedent Armed Forces' 1 Tyas 2 the Yes, Give Yaar or Detes:	2				ispanic Origin? ( in, Mexicen, Pue Specify:	Specify Yes or No rto Rican, etc.)		ace - Amari lack, White,			
Completed	(Spe	15. Decedent's Ed ecity only highast gre condary (0-12)	lucation da completed) College (1-4or	5+)			el Occup ork done se retired	ation during most of wi f)	orking	16b. Kind of				
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Be									ama (First, Middla,		ama)			
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ury or other		sposition  Cremetion 3   Other (Specify		20b. P	lece of Disposementery, crements Have	etion (Ner eatory or o	me of other place mete	ery	Nov 13	20c. Location				
- BODD	AN	neral Service Licen	10	cco34				ss of Fecility	Latnev's	Funera	1 Hom			
ian cal	anti Enter shock, or he Immediate Causa	the phease, or compart failure. List only	oligations thet cause one ceuse on eech I			or the mod	eorc	g, such es cardi	NW WASHII ac or respiretory a	rrest,	.0011	Approxim Interval B Onset end	etween	
ner	disaese or conditi resulting in death	ion	a											
ě			Ascad		r es e consequ	uence of):					1			
Examiner	Sequentially list of it any, leading to ceuse. Enter Und Cause (Disease of	conditions, immediate derlying	b		r es e consequ	uence of):								
Se as the bunar-transm Medical Examir	thet initiated even resulting in death	its The second	d	Due to (or	es a consequ	iance of):								
Cian	Deat II Other stee	Minant annellation and			Marie Tellah a se	ale di le c			005 014	4-1	1			
Physician/M	Part II. Other eign	ificant conditions co	ontributing to death t	out not rase	uning in the un	denying d	euse giv	en in Per( I.		tobacco uee d Yes 2□ No				
y Pt									24e. Wes	an eutopsy	an Co	ere autops vallable prio empletion of	or to	
s should be a					_				penc		O	death?		
2 should be d					_				10			□ Yes 2	□ No	
ector, page 2 should be d Be Completed by	25. Wes case rafe axeminer?	erred to medical	Hagaital				l Oib			Yas 2 ⊠ No			□ No	
To Be Completed by		] No	Hospitel: 1 Inpati	iry	ER/Outpatient 28b. Time of Injury	-	28c. Injur Wor	er: 4 Nursing	10	Yas 2 ⊠ No one) dence 6 □C	1 Other (Speci	☐ Yes 2	□ No	
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DHMH 16 Rev 6/95



requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: **Physician** 

Examiner

**Funeral** 

Director

r 28a-f show a notified at

7 is marked other than "natural", or items 23s or traumatic event, the Madical Examiner must be a

permit. Pages 1 and 2 ahoud be filed within 72 hours after dear Deportant if them 27 is marked other the result of

**Physician** /Medical

Examiner

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After this

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Funeral Director: A

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	500 10 (	or es e consequence orj.			
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b. Due to (	or es e consequence of):			
Ceuse (Disease or injury thet initiated events resulting in deeth) Lest	cDue to (c	or es a consequence of):			
Pert II, Other significant condition	contributing to death but not res	sulting in the underlying c	euse given in Pert I.	23b. Did tobacco use con	ntribute to the cause of death?
				1 ☐ Yes 2 ☐ No	3 Probably Unknown
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings evellable prior to completion of ceuse of deeth?
				1 Yes 2200	1 □ Yes 2 No
25. Wes cese referred to medicel exeminer?				eeth (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2	A/Outpetient 3 DC	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Manner of Deeth  1 Deturel 5 Pending 2 Accident investiga		28b. Time of Injury M	8c. Injury et Work? 1 Pes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could no determin		nome, ferm, street, fectory	, office	28f. Location (Street end Numb City or Town, Stete)	per or Rurel Route Number,
				ce, and due to the cause(s) and ma curred et the time, date end piece,	
29b. Signature and title of certifier		290	. License number	29d. Dete signe	d (Month, Day, Year)
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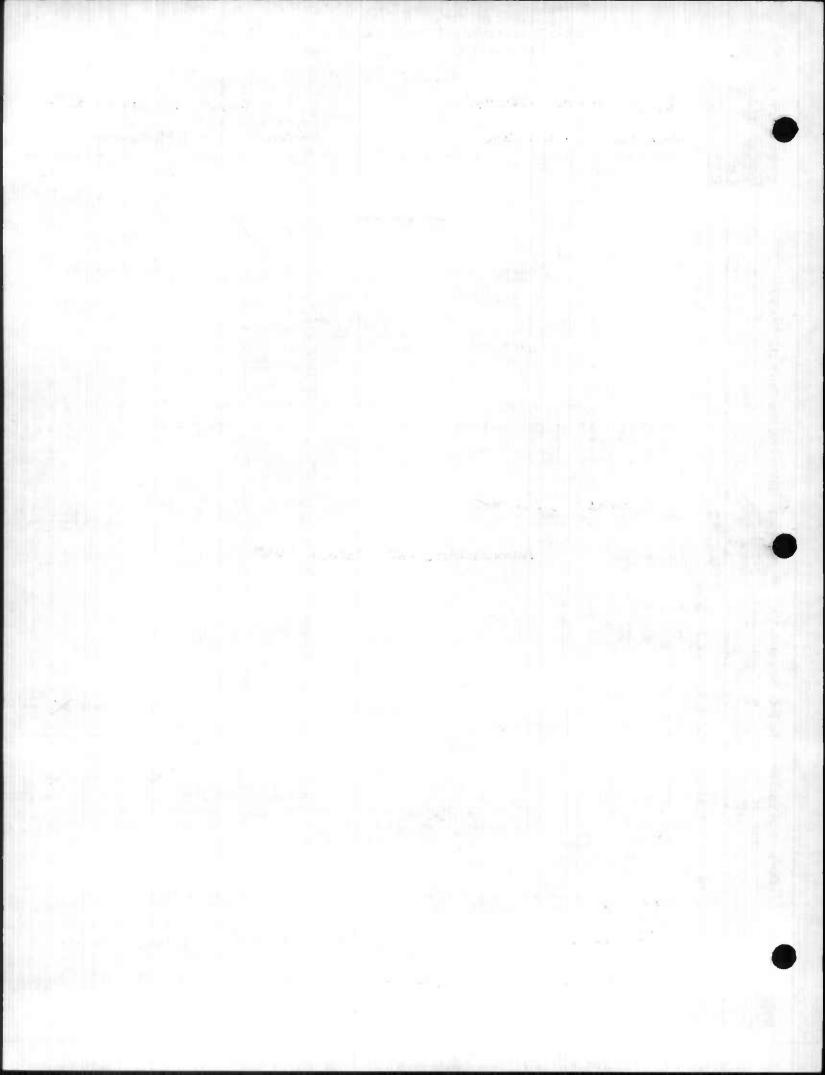
State Registrar

31. Date filed (Month, Dey, Year)

MARGOUS, MO. 11/25 ACCRUINT PIET, POCKVING, MO 20852

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 9 AMEND ITEMS: 19A-B PER ANATOMY BOARD Certificate of Death O WR. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** HARRIS BABY A (un named) 1999 Dec. 04:40 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore 7. Age (In yrs. last birthday) If Under 1 Yeer Months Deys Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F NONE Director M Usuel Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at N/A Baltimore 1 No Yes 2 No Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21217 USA 2502 Druid Hill Ave Items 23s Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than "natural" —— any injury or other traumatic averages. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried specify: black 1 Yes 2 No Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) none none none none 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 unknown Teneara Harris 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a Informant's Name/Relationship (Type Print)
TENEARA HARRIS MOTHER
2502 Druid Hill Ave Balti MD 21217 2502 DRUID HILL AVE. BALTO, MD 20b. Place of Disposition (Name of carnetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 ♥ Other (Specify) in state rvice Licensee 21. Signature of Funeral Se ROTALO State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Perf1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betwe Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Prematurity Examiner Due to (or as a consequence of) Examine ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medicai the Due to (or as e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? X Neturel 5 Pending 1☐ Yes 2☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 7, ZOOO P13879 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St., Baltimore, Md 21201

DHMH 16 Rev 6/95

State

Registrar

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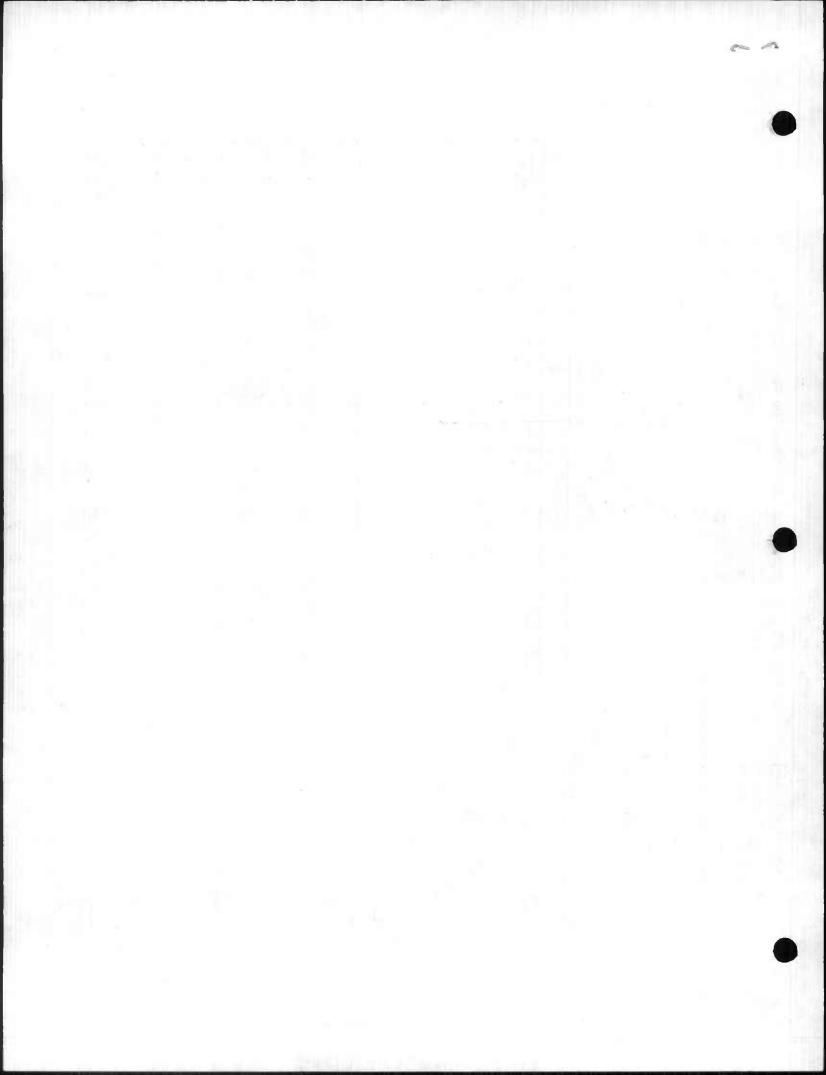
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31. Dete filed (Month, Day, Year)

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32. Registrar's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ician dical niner			st)			ficate of		2. Date of Dea			3. Time of Death
ner	Ethel M. 4a Facility Name (If		e street and numb	or)			4b. City, Town, or I.	Month DECEMBE	R 10, 1	999 1	0:22 AM
	20 Shady Ri	dge Court					Parkton		Balt	imore	
	5. Social Security Nu 218-01-8358	1	ех	Age (In yrs. 78		If Under 1 Year Nonths Days		8. Date of Birth (Month, Day Sept. 16,	1921	9. Birthplac Country	e (State or Foreign )
	Usual Residence of I	Decedent 10b. County		10c. Cit	y, Town or Loca	tion				10d.	Inside City Limits
ctor	MD	Baltimor	re		Parkton						1 ☐ Yes 2 No
al Director	10e. Street and Num 20 Shady Ri					10f. Zip Code 2112	?0		USA	What Country	?
ay i diloidi	11. Merital Status  1 Never Marrie  3 Widowed 4	No. of the State o	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? [3] No	1100	s Decedent of Hes, specify Cub  Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Prican, etc.)	Blac	e - American ck, White, etc	
		15. Decedent's Ed y only highest gra dary (0-12)		or 5+)		nt's Usual Occup ed of work done NOT use retire Sewife	pation during most of work d)	king	16b. Kind of Bu		atry
	17. Father's Name (F				nou	Sewile	18. Mother's Nem	ne (First, Middle,		-	
	Robert Ocy						Marie	Steele			
0	19a. Informant's Nam	ne/Relationship (	Type, Print)		19b. Mailing	Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Co	ode)
	Charles Ja	mes / son				7 7	Court Parkt	on, MD 2	1120		
			Removal from Sta		Place of Dispositi semetery, crema	ion (Name of tory or other pla	ce)	Date	20c. Location -	City or Town	, State
	21. Signature of Fundamental Ronald		)irector PE	R OVR		eet Balt	. 30	ate Anato	my Board	655 W.	Baltimore
Examiner	Immediate Cause (F disease or condition resulting in death)  Sequentially list condition if any, leading to imm		b. PRO	Due to (c)	r as a conseque	nce of):  ACUTE  nce of):	DEAT MYOCA	H MOJAL	INF	FARCTI	101
3 3 3	Sequentially list condit any, leading to immoduse. Enter Under Cause (Disease or that initiated events resulting in death) Ls	ying ijury	c. 144	perto (o	nS10 m					Su	realyca
	Todding in Godgify Le		0. 144	perli	pener	ż.					11
Physicianim	Part II. Other signific	ant conditions o	ontributing to deat	h but not res	ulting in the unde	erlying ceuse giv	ven in Pert I.	23b. Did to	obacco use co	ntribute to th	ne cause of death
	NIDO	m, Ci	olon ca	n Ce	1,60	east	is CVA	101	aa 2□No	3 Probat	oly 4 1 Unknow
Completed by	Pept	ic W	lier d	Isea	184,1	revor	SCVA	248. Was a perfor		availa	autopsy tindings able prior to letion of cause ath?
5								1 U Y	es 2DNo	1 🗆 Y	'es 2□ No
2	25. Was case referre examiner?	d to medical	Hospital:			04		th (Check only or	10)		
cei illication. 10	1  Yes 2 2 N  27. Manner of Death 1  Natural 2  Accident	5 Pending investigation	1 ∐ Inp 28a. Date of I (Month,		28b. Time of Injury	28c. Inju		ome 5 D Aesid 28d. Describe h			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. Place of	Injury - At he etc. (Specif	ome, farm, street	, fectory, office		28t. Location (S City or Tow		per or Rural R	loute Number,
	29e. Certifier 1 (Check only 2 one) 2	Certifying Ph	ysician: To the be niner: On the basis and manner	s of examina	wledge, death or tion and/or inves	courred at the tid tigation, in my o	me, date and place, opinion, death occur	end due to the c rred at the time, o	ause(s) and ma late and place,	anner as state and due to th	ed. e cause(s)
edical		to all an AM:		1100		29c. Licens			29d. Date signe		
Medical	29b. Signature and til	r /	completed cause of	4	_	_				_	

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State of Maryland / Department of Health and Mental Hygiene

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Certificate of	Death		Don No

3. Time of Death

10d. Inside City Limits

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Approximate Interval Between Onset end Deeth

1 Yas 2□ No

1999 0706 AM

that the death certificate be executed 980 by The law requires Completed page 2 To the Hospital or Attending Physicien: Be Certification: To this After after death.

of Vital Records,

Division

1. Decedent's Name (First Middle Last) 2. Date of Deeth Month Dey
DECEMBER 26, **Physician** Wilhelm Jorgensen /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth De Month, Dey 1998 Birthplace (State or Foreign Country)unknown 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min. 10 M 2□ F 61 unknown Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show reast be notified at unknown unknown unknown Director 10e. Street and Number 10f, Zip Coda 10g. Citizen of What Country? USA unknown unknown Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? or Items 11. Maritel Status 1 Never Merried 2 Married filed within 72 hours after 1 Yes 2 No
If Yas, Give unknown
Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hyglene. unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o unknown 7 is marked treumetic a unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other treu 111 Penn Street Baltimore, MD O.C.M.E. 20b. Place of Disposition (Name of cematery, crametory or other place) 20c. Location - City or Town, Stete 20e Method of Disposition 1 ☐ Burief 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 MOther (Specify) in state 21. Signature of Funerel Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director Much wel Baltimore, MD 21201 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Box 68760, Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of deetb2 24a. Wes en autopsy performed' 1 Yas 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) exeminer

Hospitel: 1 ☐ Inpatient ②□ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2 No 3□ DQA 28b. Time of Found c. Injury et Work? 28d. Describe how injury occurred
Suggest ex 27. Menner of Death 28a. Dete of Injury (Month, Day Year) en uronment 5 Pending investigation 1 Netural М 1 Yes 2 No 26 0600 2 Accident 3 Suicide 6 Could not be 28e/Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City.or,Town, Stete) 4 Homicide Street yette Stand Highland

Baltomere, Ml Bus >404 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and gue to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signatura and fitla

29c. Licensa number O.C.M.E.

oorks

29d. Data signed (Month, Dey, Year) DECEMBER 27, 1999

30. Name an completed cause of death (Item 23a) (Type, Print)

- 111 Penn Street, Baltimore, Maryland 21201 Tones JAN 2 4 32. Register's Signature

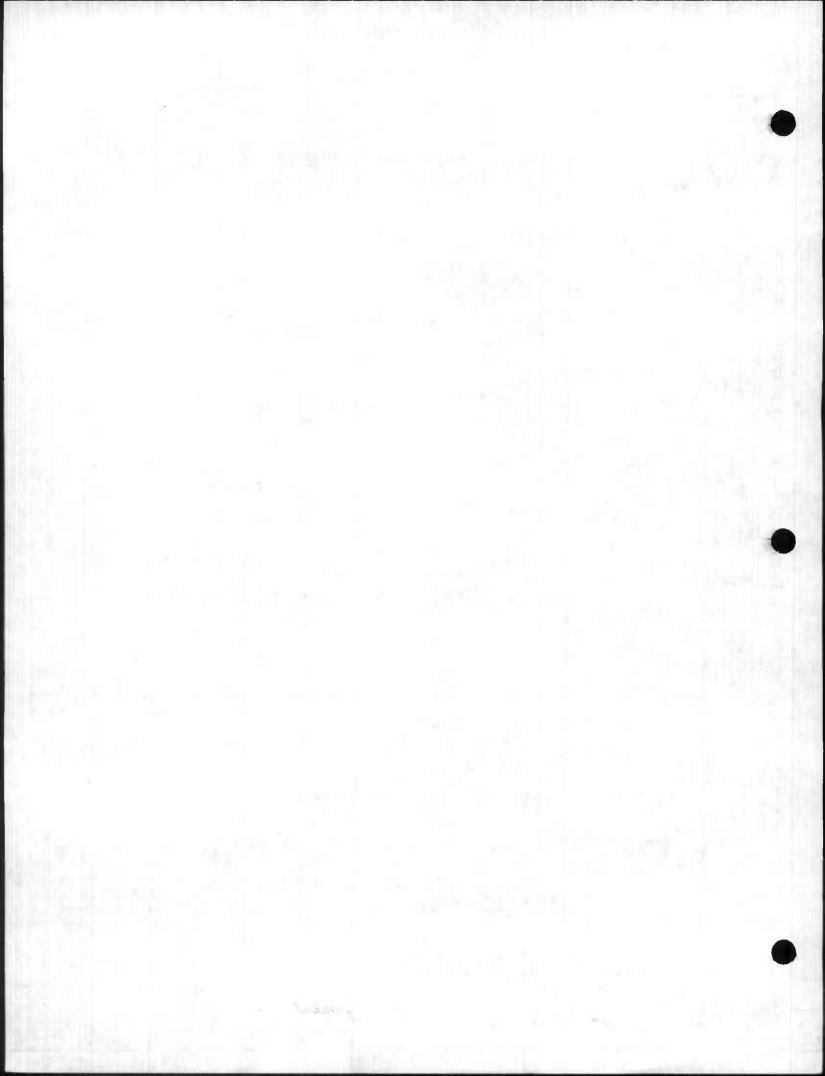
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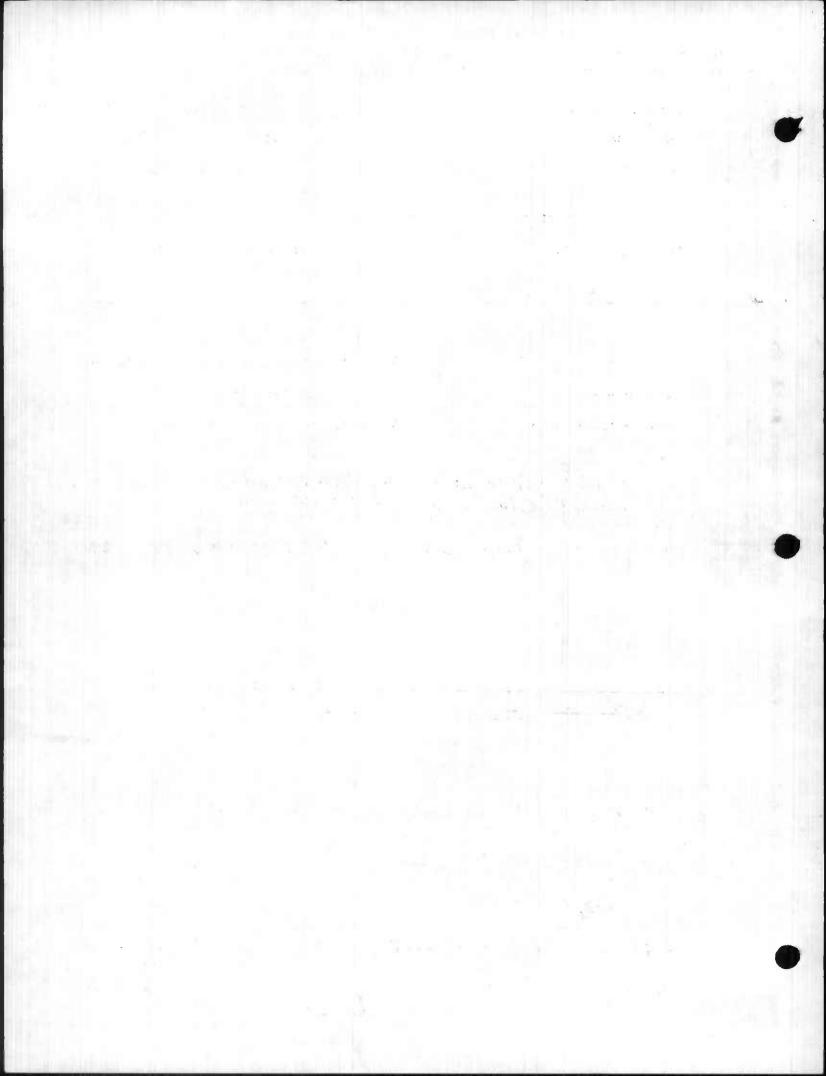


Item 27 per DR, G7802/16/00dhb State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Amended Item#23aptII perPhyG779 1/21/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dafa of Death 3. Time of Death **Physician** December 23, 1999 Kenneth J. Kyle 2:30 PM /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joppa 413 Arcadia Drive Harford | Honder 1 Year | Honder 24 Hrs. | S. Dafa of Birth (Month, Day, Year) | Sept 30, 1939 7. Age (In yrs. last birthday) 60 Yrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1**X** M 2□ F 482-46-7775 Yrs. Director Iowa Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Harford Joppa r 28a-f a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò r than "natural", or items 23a or the Medical Examiner must be 21085 USA 413 Arcadia Drive Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give X Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, Whife, efc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or its 1 Never Marriad 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: þ 3 ☐ Wirlowed 4 ☐ Divorced "natural". white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto instructor education

18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) Be Lyle J. Kyle Dorothy Fehr 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and emportant: If them 27 is n enty Injury or other treum once. Delores Kyle/spouse 413 Arcadia Drive Joppa Md. 21085 20b. Place of Disposition (Name of cematary, crematory or other placa) 20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Nama and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Pint. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, s buk, or heart feiture. List only one cause on each line. Approximate Interval Between Onsef and Death **Physician** SMAN CEN LUNG CANCER 6MONTHS /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner ician and buriel-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lasf Due to (or as a consequence of) physician the burie Box 68760. certificate be Physician/Medical Due to (or as a consequenca of): 88 980 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE CEREBROVASCULAR ACCIDENTS Records, p 24b. Were autopsy findings availabla prior fo completion of cause of death? 24a. Was an autopsy Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident or Attendation of the death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of 24 hours a Funeral D 29e, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. edical To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signatura and fitle of config 29c. Liçense number DECEMBER 29, 1999 who completed cause of deeth (Item 23a) (Type, Rrint) DUANDS m. J 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time f th **Physician** Beulah Mae Lawrence Month 3 09y 6:30 F /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | 1 (Months | Days | Nonths | 1 (Months | Days | Nonths | 1 (Months | Days | Nonths | 1 (Months | Days | Nonths | 1 (Months | Days | Nonths | 1 (Months | Days | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Nonths | Non 9. Birthplaca (Stata or Foreign **Funeral** 1 M 2 TF 232-32-7111 Maysville, WW Director Usuai Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at Director Tucker 1 yas 2 No Davis 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 PO Box 691 26260 items 23a USA Peges 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Items 23. Funerai 12. Was Decadant Evar in U,S Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yes, Giva Y Yaar or Datas: Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: White 3 Widowed 4 Divorced Completed 15. Dacedant's Education 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) Cottaga (1-4or 5+) 10 Quality inspector Retail 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Andrew Christian Rohrbaugh Nora Mae Goldizen 19a. fnforment's Name/Reletionship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trat once. Betty Sponaugle PO Box 145 Davis WV 26260 Baltimore, 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata Data Burial 2 Cremation 3 Ramoval from Stata camatary, cramatory or other place)
Rohrbaugh Cemetery 1-2-00 Dry Fork, WV 22. Nama and Addrass of Facility
Hinkle Funeral Home, Inc. PO Box 186, Davis WV 26260 PO Box 186, Davis WV 2

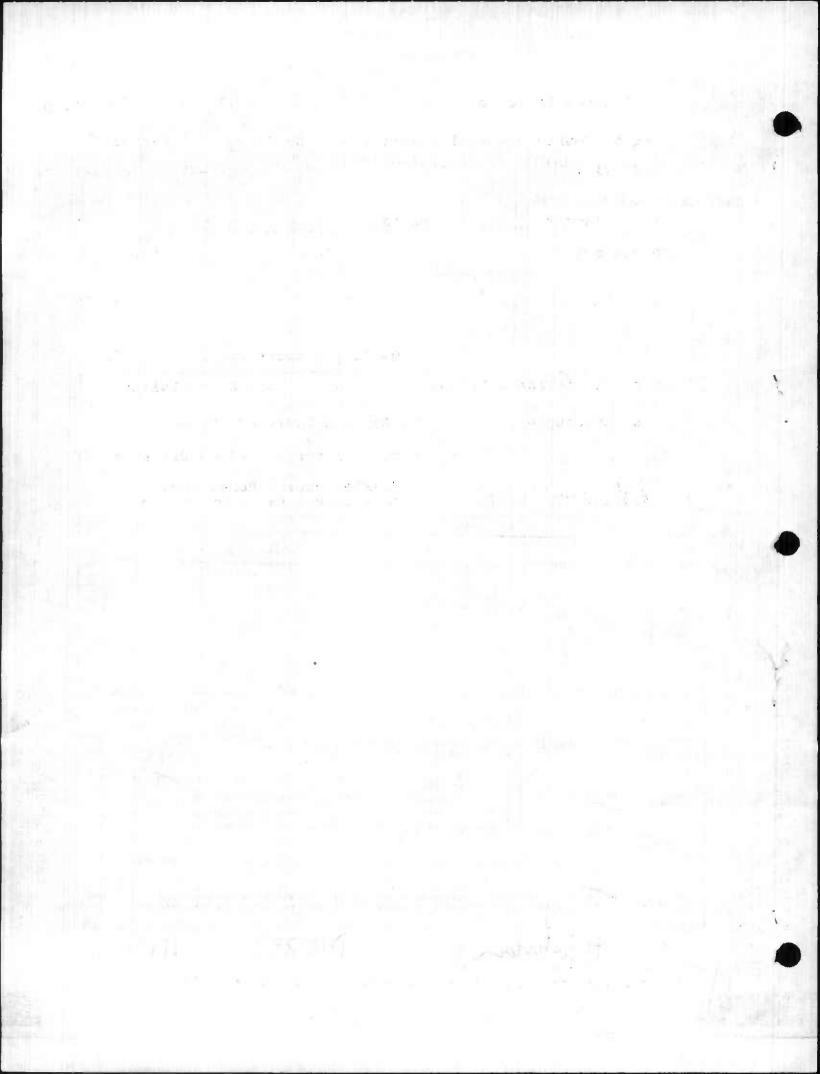
23e. Pert1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Batween Onsat and Deeth **Physician** /Medical tmmediate Causa (Final pneumonia 1 week disaasa or condition rasulting in daath) Examiner Examiner chronic obstructive pulmonary disease/respiratory vears The law requires that the death certificate be executed buriel-transit failure Sequantially tist conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or injury thet initiated avants rasulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760. ettending physician for use as the burie Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown atherosclerotic heart disease/sp myocardial infarction þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? high blood pressure certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No l or Attending Physician: after deeth. Be 25. Was cesa rafarred to medicet 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 □ DOA 2 1 Yas 2 No After this 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No 24 hours after deet Funerel Director: In by the 6 Coutd not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ HomicIda Hospital Certifying Physician: To the best of my knowladge, daeth occurred at the time, deta end place, and dua to the ceuse(s) and manner as stated.

| Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar within 24 ho To the Fune Completaly fi 29b. Signatura and titla of certifie 29c. Licensa number 29d. Data stgned (Month, Day, Year) 30. Nema end addrass of person who complated ceuse of death (Itam 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 31. Data fliad (Month, Day, Year) 32. Regtstrar's Signatura Sta e

DHMH 16 Rev 6/95

Registrar

JAN 1 9 2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

			State	i iviai yiai iu /	Department of t
Thomas	Anthony	McKnight			Certificate of

Reg. No.	9 1	2809
2. Date of Death Month Day	Year	3. Time of Death
December 24	1999	02:15 AM

29d. Date signed (Month, Day, Year)

December 25, 1999

**Physician** /Medical Examiner

**Funeral** 

Director or 28a-f show 234 or items filed within 72 hours after natural then

Physician/Medical Examiner The law requires that the death certificate be executed use as the Be Completed by page 2 should be this certificate Certification: To After

Funeral Director Baltimore, Maryland 21215-0020 h and Mental h Pages 1 and 2 should be Department of Health ar Important: If Item 27 Is any Injury or other traugates. **Physician** /Medical Examiner Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: death. ofrector: / the filled in by Thin 24 hours a Medical To the

1. Decedent's Name (First, Middle, Last) Thomas Anthony McKnight, Sr. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Martin Luther King Blvd. & Flaggstaff Rd. Landover Prince George's If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer)
Jun. 25, 1956 5. Sociel Security Number 8. Sex 10 M 2 F 9. Birthplace (State or Foreign Country)
Wash., D.C. 7. Age (In yrs. lest birthdey) Months Deys 43 577-74-5232 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Md. Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 9113 Fowler Lane 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Never Married 2 Merried 1 Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Lawrence Hill Barbara Hamilton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnforment's Neme/Reletionship (Type, Print) 9113 Fowler Ln., Lanham, Md. 20706 Catherine McKnight (Wife) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ND Buriet 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill Cemetery 1 - 17Clinton, Md. 22. Name and Address of Facility Phillip Bell Funeral Service 21 Signature of Funeral Service Licenses 4902 Stan Haven Rd., Temple Hills, Md. 20748 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 2€R/Outpatient 3□ DOA 1⊠ Yes 2□ No 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Neturat 5 Pending investigation Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 6466 1 Yes 2 Accident 3 Suicide 6 Could not be 4 Homtcide roodera 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s)

State Registrar

DHMH 16 Rev 6/95

Theodore King M.D. 31. Date filed (Month, Dey, Year) JAN 2 7 2000

29b. Signature end title of certifier

29a, Certifier

32. Registrar's Signature

Leeath (Item 23a) (Type, Print)

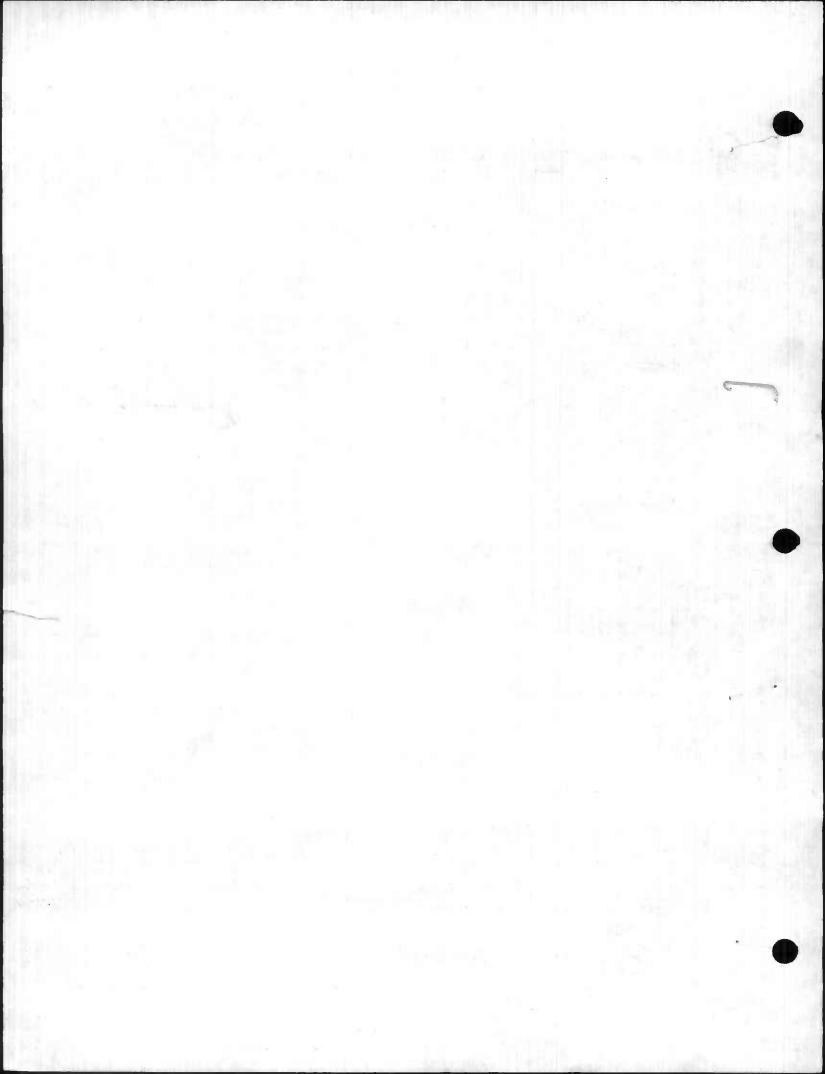
end menner steted.

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

30. Neme and address of person who completed cause



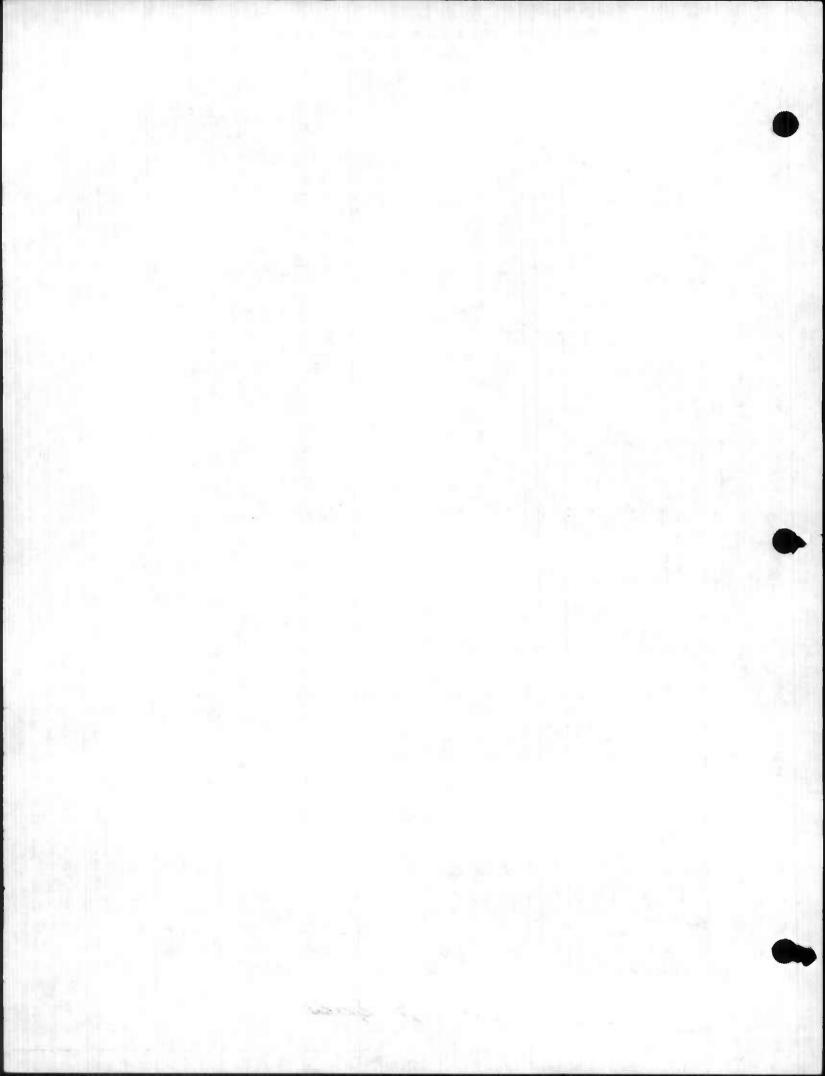
99-7859-510

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hysician	ND ITEMS: #23 PAR  1. Decedent's Name (First, Middle, I	Last)	JA LIEV	Penartment of Certificate of	Dodin	2. Date of Dear			Time of Death
/Medical	NATHANIEL NOBLE  4a Facility Name (If not institution, )		r)		4b. City, Town, or	DECEMBE:	R 29, 19		15P.M.
xaminer	UNION MEMORIAL H		,		BALTIMO				
neral ector			Age (In yrs. last birt 48	Months Dave	If Under 24 Hrs. Hours Min.		Year) 1951	9. Birthplace Country) UNKN	(State or Foreign
	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location				10d le	nside City Limits
ust be rectified at	MD N/A			timore					Yes 2 No
Director	10e. Street and Number		Dai	10f. Zip Code		1	Og. Citizen of V	Vhat Country?	
I D	2524 N. Charles	Street		2121	8		U	JSA	
by Funeral	11. Merital Status Unknown  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? ] No	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Puerl	pecify Yes or No- lo Rican, etc.)		e - American Inck, White, etc.	
Ped	15. Decedent's	Education	unknown	Decedent's Usual Occup	pation		16b. Kind of Bu	usiness/industry	y
Completed	(Specify only highest ( Elementary/Secondary (0-12)	College (1-4o	r 5+)	(Give kind of work done life. DO NOT use retire	during most of word)	rking			
Соп	unknown	unkno		unknown			unkr		
Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Nar	me (First, Middle, I	Maiden Sumam	10)	
To	unknown	Con Dian	405	Barillan Addans (Canada	and March and Co	unknown	Chi es Taus	State 7in Cod	51
	19a. Informant's Name/Reletionship  O.C.M.E.	(Type, Print)		Mailing Address (Street 111 Penn St					0/
	20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Dother (Special Control of Control	□Removel from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla			MD 212 20c. Location -		State
	21. Signeture of Funeral Service Lice Ronall d S			State Anat Baltimore,			Baltimo	ore Str	eet
	23a. Part1. Enter the disease, or of shock, or heart feilure. List on				ing, such as cardia	c or respiratory arr	est,	Inte	proximate rivel Between set end Death
al er	Immediate Cause (Final disease or condition resulting in death)	aP	ONTINE H	EMORRHAGE					
ē		1137		consequence of):	COLULAD D	CDACE		100	
i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. HY	Due to (or as a	VE CARDIOVA	SCULAR D	LSEASE			
Physician/Medical	that initiated events resulting in death) Last	d	Due to (or es e o	consequence of):					
Clar	Part II. Other significant conditions	contributing to death	but not reculting in	the underlying cause of	iven in Part I	23h Did to	phaceo use co	ntribute to the	cause of death?
by Phys	Part II. Other significant conditions	contributing to death	but not resuring in	the underlying cause gr	ven in Part I.		ee 2□ No		y 4 Unknown
Completed b	37					24a. Was a perfor		availab	utopsy findings le prior to ition of cause h?
mo:						130 Y	es 2 No	176140	s 2 No
Bec	25. Was case referred to medical				26. Place of De	eth (Check only or	10)		
To	examiner? 1 X Yes 2 □ No	Hospital: 1 1 Inpa		tpatient 3LI DOA		lome 5 ☐ Resid	ence 6 Oth	er (Specify)	
	27. Manner of Death  1 Netural 5 Pending 2 Accident investiget 3 Suicide 6 Could not	be on Diese et	Day Year) I		iry at ork? ] Yes 2 □ No	28d. Describe h			uto Alumbar
0	4 Homicide determine	building.	etc. (Specify)	rm, street, factory, office		City or Tow	n, State)		
Certification:			of exemination en	, death occurred at the ti d/or investigetion, in my		urred et the time, d			
Aedical Certific	(Check only one) 27 Medical Ex	end menner	stateo.				AND DOLL	d Mannet B	Manual
Medical Certific	(Check only 2 Medical Ex	end menner	m.D.	29c. Licen	se number		9d. Date signe		
edical	(Check only 2 Medical Ex	M. ZL	m.D.	O.C		Di	ECEMBER	31,199	9

DHMH 16 Rev 6/95

me SARE



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hartha Peirson 26 Dec. 1999 12:35PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton, Maryland Sunbridge Care and Rehab Cecil | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Oct. 03 1899 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XF 221-07-3822 100 Yrs. Director Usual Residence of Decedent the Maryland a notified at 10b. County 10c. City, Town or Location 10e. State 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Yorklyn Delaware New Castle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be c 19709 P. O. Box #87 Name 23a USA death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status than "natural", or han Bleck, White, etc. filed within 72 hours after Hygiene. Hygiene. Wher then "natural", or its 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White ğ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Departit. Pages 1 and 2 should be filled with Capatinent of Health and Nemal Hygien Important if New 37 is marked other the any Injury or other traumatic event, that dates. Unknown Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles Peirson Elizabeth 0. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Howard A. Magargal (grandson) 129 New Road, Lewes, Delaware 19958 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 288B. Silverbrook Crematory 4 Donation 5 Other (Specify) Wilmington, Delaware 21. Signaturit of Funeral Service Lipe 22. Name end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each lib Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Cardiopulmonary Failure disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner **ASVS** physicien and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. HTN Physician/Medical Due to (or as a consequence of): 080 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? certificate has been a lirector, page 2 should Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 XNursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred efter deeth. Director: After ti 5 Pending 1 X Natural 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) á 4 Homicide 24 hours efter Puneral Dire letely filled in b Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

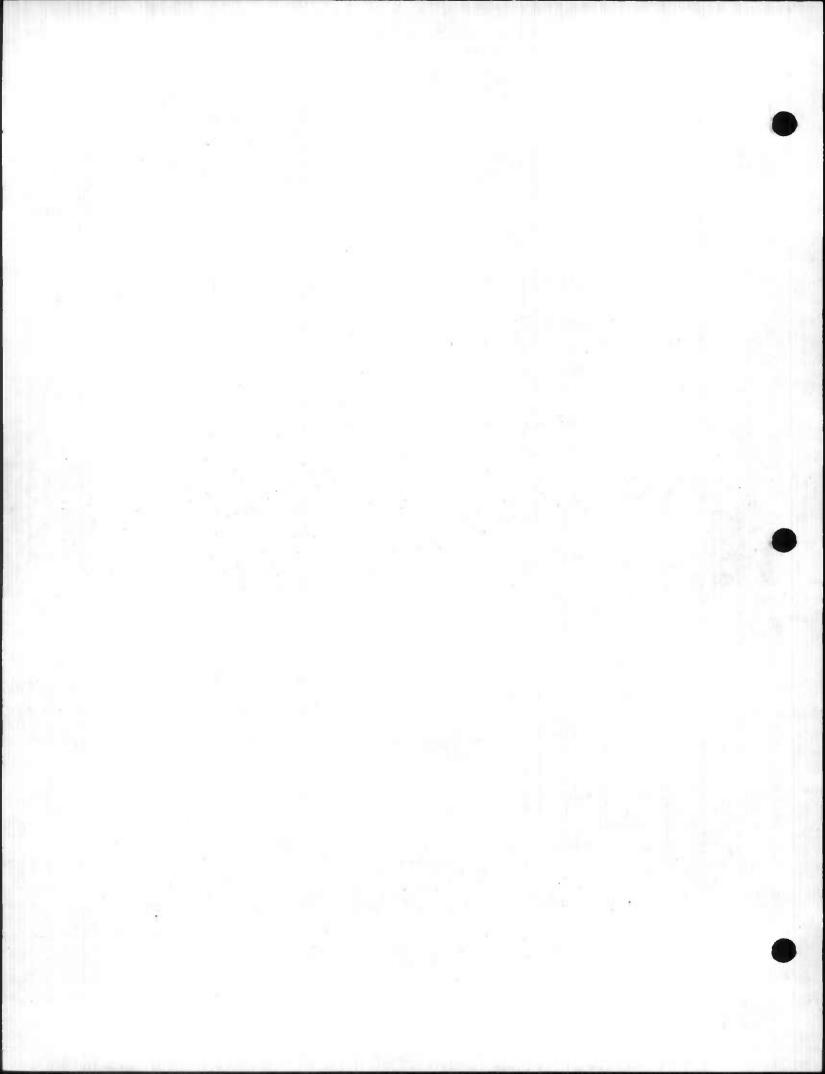
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier To the Hosp within 24 ho To the Fune completely fi ner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner steted. (Check only 29b. Signature and title of cogifier 29c. License number 29d. Dete signed (Month, Day, Year) December 27, 1999 H0055026 1 dress of person who comple med cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) 3. Registrar's Signeture

Dr. Stephen Naylor, MD.

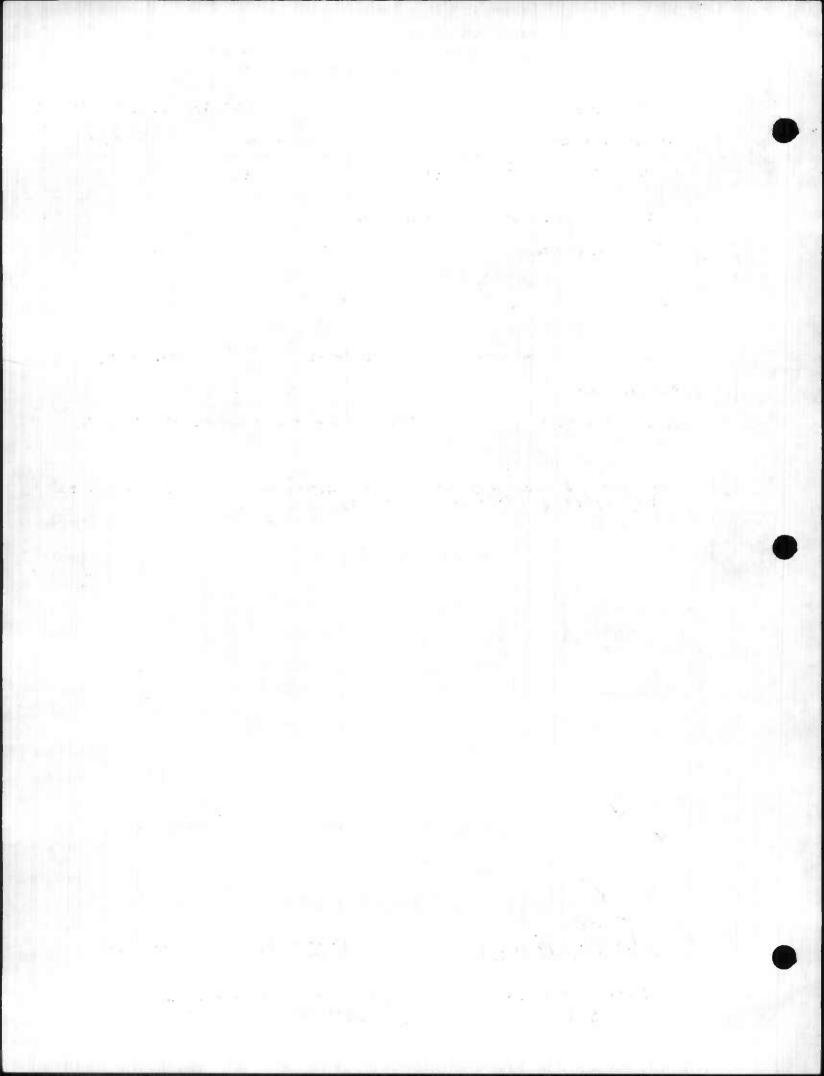
20 Craigtown Road, Port Deposit, Maryland 21904



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State of Maryland / Department of Health and Mental Hygiene 9 4 28 1 2

			(	Certificat	e of	Death		Reg. No.	76	.016.
	1. Decedant's Nama (First, Middla, La	st)					2. Data of D	Peath Day	Yaar	3. Time of Death
Physician /Medical	HAZEL RUDOLPH						DECEME			1:15 PM
Examiner	4a Facility Nama (If not institution, give	a street and number)				4b. City, Town	, or Location of Des	th 4c. County	of Death	
(位) [[1]	514 Patterson Ave	nue				Cumbe	rland	A.	llegh	eny
Funeral Director	5. Social Sacurity Number 6. S 212-38-6268	□M aME	last birth	Months	1 Yaar Days		Min. (Month, L	irth Dey, Yaar) , 1912	9. Birthp Coun	laca (Steta or Foraign try) WV
of Bu	10a. State 10b. County	10c. C	ty, Town	or Location					1	0d. Inside City Limits
vith the Man s or 28a-f sh be notified.		egheny	Cum	berland						1☐ Yes 2√ No
23s or 3 ust be n	10e. Street and Number 514 Patterson Av	enue		10f. Zij	1502	2		10g. Citizen of V USA	vnat Coun	try7
0020 ours after death with the Marylar rait, or Hems 23s or 28s-1 show Examinar must be notified at 1 by Furneral Director	11. Meritel Stetus  1 □ Navar Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armad Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	J,S.	13. Was Dece If Yas, spe 1 \(\sum \) Yas	cify Cub	en, Maxican, I	n? (Specify Yes or N Puerto Ricen, atc.)		k, Whita,	en Indian, atc. 'hite
15-002 n 72 hours "natural", adical Exu	15. Decedant's Ed (Specify only highast gra	lucation da completed)	16a. D	acedant's Usu Giva kind of wo	al Occup	petion during most o	f working	16b. Kind of Bu	siness/inc	dustry
omp	Elamantary/Secondary (0-12)	Collaga (1-4or 5+) unknown	'/	Giva kind of wo ifa. DO NOT u beaut				cosmot	01003	7
and Shied of the stand of other event, I Be Co	17. Fathar's Nama (First, Middla, Last)	dikilowii		Deaut	ICIC		Name (First, Midd			/
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Marylar 42 should be b and Menta 7 is marked treumetic ex	19e. Informent's Name/Reletionship (	Type, Print)	19b. I	Meiling Addras	s (Straet		or Rural Routa Num		Steta, Zip	Coda)
Marity ar treu	Richard Rudolph/s	son	10:	300 Co1	umbu	ıs Ave	NE Cumber	land, MD	215	502
Mort Herror or other	20e. Mathod of Disposition  1 Burial 2 Cramation 3 4 Donation 5 Other (Specific	Ramoval from State		Disposition (Na cramatory or		ce)	Data	20c. Location -	City or To	wn, Stata
Baltim permit. Pa Department Important any injury once.	21. Separture of Funeral Sarvice Licen Ronald S.	wade, Director		State	. An		Board 655	W. Balti	more	Street
Physician	23a Part 1 Entar the diseasa, or com hock, or haart failura. List only	plications that causad tha dea ona causa on aach lina.	th. Do no			e, MD ng, such as ce		errest,		Approximeta Intervel Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a Congesti	ve He	eart Fa	ilur	е				greater
The state of	and the state of t	Dua to	or as a co	onsaquance of)						than five years
60, be executed coan and bunal-transit	Sequantially list conditions, if any, laeding to immadiata causa. Enter Undertying Ceuse (Diseese or Injury that initiated avents	Due to (	or es a co	nsequence of)						
c 687	that initiated avents rasulting in death) Last	Dua to (	or as a co	nsequance of):						
death east for us	5 - 1/ 64 - 1 - 14 - 1 - 14		44- 1-4				and Di	4.4-1		the severe of death?
P.O hat the od by th detech	Part ii. Other significant conditions of	ontributing to death but not ra	sulting in t	he undanying	eusa gr	van in Part I.		Yes 2 No		bably 4 Unknown
cord requir been s should			_				24a. We	es an eutopsy formad?	CO	ara autopsy findings eilebla prior to mplation of causa daeth?
							10	Yas 2 No		Yas 2□ No
F Vita	25. Wes case rafarred to medicel exeminar?						f Daath (Chack only	( ona)		
- S S D	1 ☐ Yas 2 No		ER/Outp		JA		ing Homa 5 Ra			y)
Attending Plant death.  ector: After the by the funeral iffication:	27. Mannar of Daath  1 Maturel 5 Panding 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Tir Inj	me of ury M	28c. Inju Wo 1 []	ryat rk? ∣Yas 2 🗌 No		e how injury occur	red	
er ingle	3 ☐ Suicida 6 ☐ Could not be datermined	28a. Plece of Injury - At I building, etc. (Spec	ome, fam	n, street, fector	y, office		28f. Location City or 7	(Streat and Numb own, State)	er or Rura	il Routa Number,
To the Hospital Within 24 hours To the Funeral completely filled Medical C		ysician: To the best of my kn hiner: On the basis of examin and mannar stated.								
To the vithin 2 To the comple	29b. Signatureland tips of genifier			29	c. Lican	sa number		29d. Date signe	d (Month,	Day, Year)
- 5 - 0	Jun 2 lle	lams			DI	1604	11	01-1	8-00	
San Jan	,	completed ceuse of death (Ite								
State	31. Data filed (Month, Day, Year)	iams 3 Registrar's Sign	500 1	Memoria	AV	enue C	umberland	, MD 215	02	1 1/2



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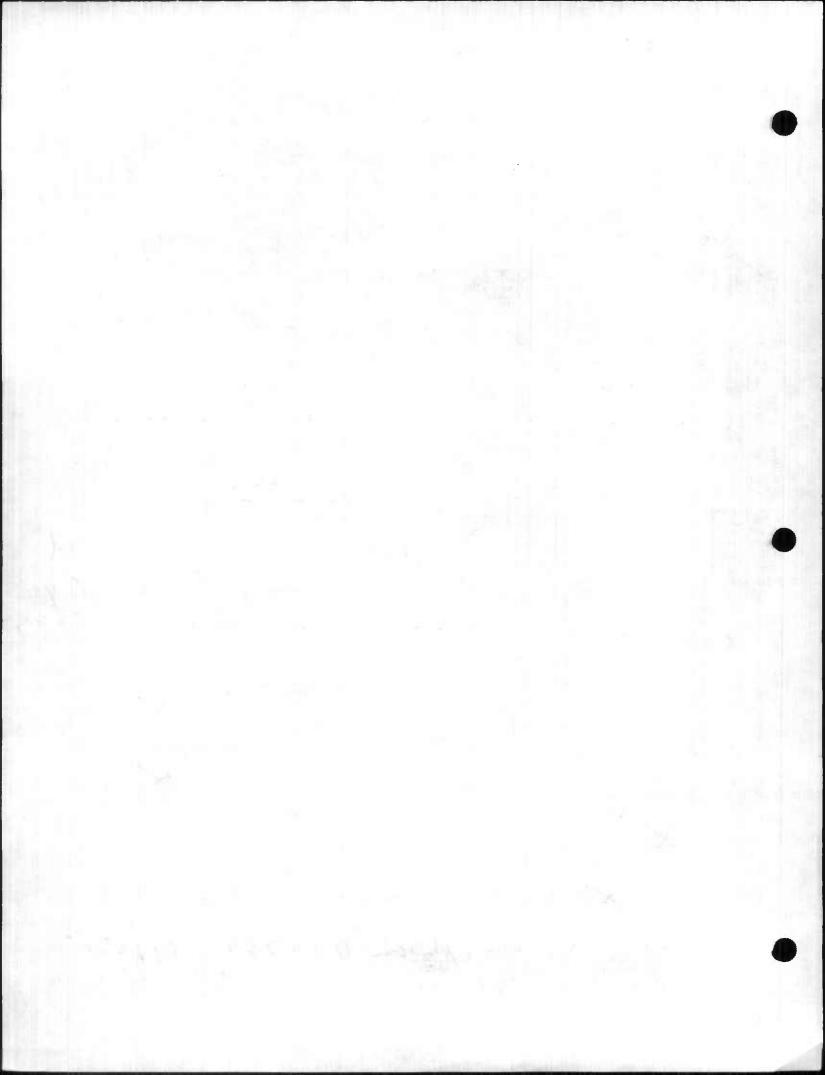
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Y. Strausser Dec. 30 1999 8:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1□ M 2Ø F Yrs Director 92 215-07-5764 01-01-1907 Maryland **Usual Residence of Decedent** with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits th end Mental Hygiene. 7 ie marked other than "naturel", or Itema 23a or 28a-f ehov treumatic event, tre Medical Examiner mint be noding at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 98 Smithwood Avenue 21228 U.S.A. deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Status filed within 72 hours after 1 Never Married 2 Merned 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked off jury or other treumatic even Be Donato Macciola Leondina 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Michael King/ Grandson 21074 2102 Moonlight Drive, hampstead, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If eny injury or 1-3-2000 New Cathedral Cemetery Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. uture of Funeral Service Lichnse 21. Sib 4107 Wilkens Ave., Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 080 ed by the et P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed pege 2 should be de Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy certificate t 🗆 Yes 200 1 ☐ Yes 2 ☐ No of Vitai or Attending Physicien: funeral director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division After 1 Naturel 5 Pending n 24 hours efter death.

The Funerel Director: After pletely filled in by the fur 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical completely (Check only er: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signalu 29c. License number 29d. Dete signed (Month, Dey, Year) 2 Can 30. Name and address of b (Item 23a) (Type, Print) e of d Wern morce and ino 31. Date filed (Month, Day, Year) JAN 2 4 2000 Registrat's Signature State Registrar

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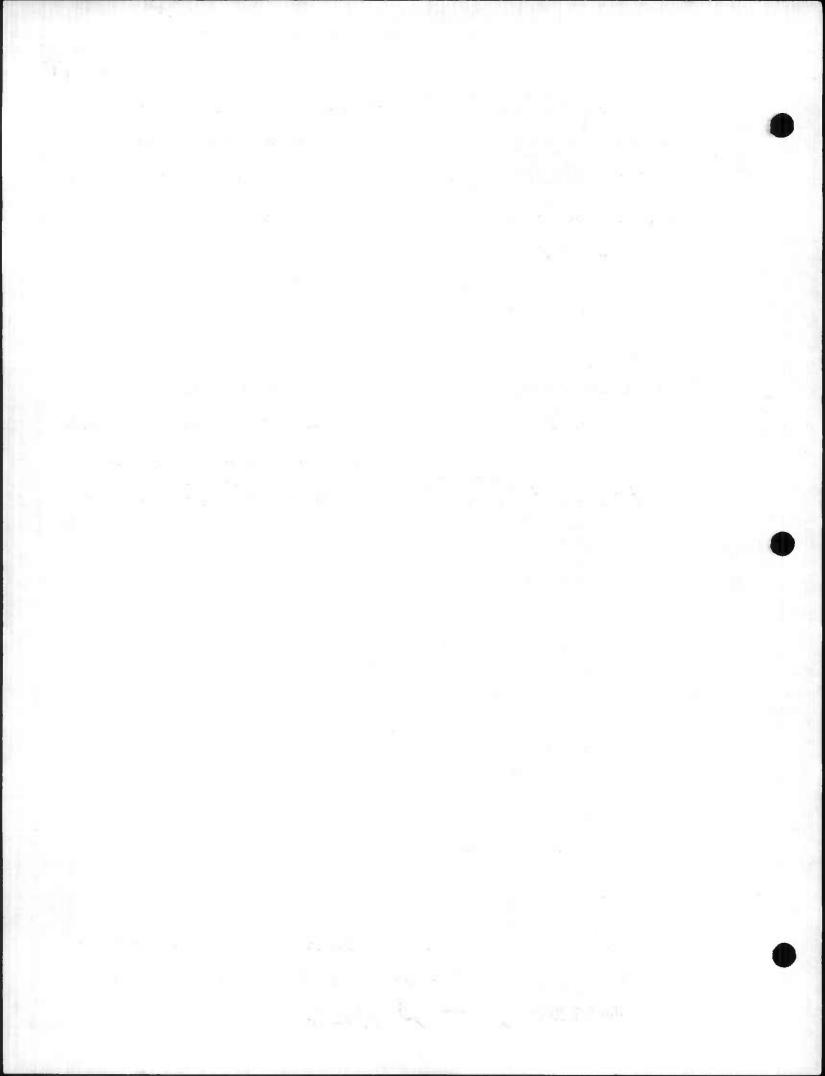
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						90e Licen	se number		29d. Data signer	d (Month C	lev Voerl
	29b. Signature ar	nd little of certifier			MARA	1	- Homboi		A Supra	4	ay, rour)

Charles I have 10 " 15 cm) hopeway a 1999

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State of Maryland / Department of Health and Mental Hygiene 99

AMEND ITEMS: #20B-C PER F.H. G7780 2-19-200 Dertificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day 1999Yeer **Physician** 31, 1:00 pm Dec mond /Medicai 4a. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Genesis Eldercare Randallstown Baltimore If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Mar 17,1919 5. Social Sacurity Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 199-03-0467 Yrs. 80 Director Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Manchester Maryland 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3080 Main Street 21102 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Rece - American Indien, Bleck, Whita, atc. 1 ☐ Yas 2 XNo If Yes, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married White 1 ☐ Yes 2 ☒ No Specify: Specify: Š 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) Tree Trimmer Asplunh Tree Co 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surnama) William Simon Alban Ida Cora Alban 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Alban, son 14224 Old Hanover Rd, Reisterstown, MD 21136 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stata Black Rock CEMETERY 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility MO0723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onsat and Deeth Physician Immedieta Causa (Final disease or condition resulting in death) iosderosis /Medical Year Examiner Dua to (or as a consequence of) Physician/Medical Examine attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): signed by the aid be detached f Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? indrone 1 Yes 2 No 3 Probably 4 Unknown ģ should 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed is certificate has director, page 2 1 Yes 2PINO 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certifica 25. Wes case refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) funeral 27. Mennar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 29e. Certifier to the tifying Physician: To the best of my knowledge, deeth occurred et the time, deta and piace, and dua to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Year) January 3, 2000 D0020964 30. Name and address of person who complated cause of deeth (Item 23a) (Type, Print) Randallstown, MD 21133 8630 Liberty Plaza Mall Jerome H. Ginsberg, M.D. 31. Dete filed (Month, Day, Year) JAN 0 7 2000 32. Registrar's Signeture State ocular Registrar



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29b. Signature end title of certitier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burk L Fulle

31. Date filed (Month, Day, Year)

JAN 1 0 2000 Salver S. Lo

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dey, Year)

JANUARY 1,2000

State Registrar

29c. License number

O.C.M.E.

al

2000 1 2000

99-7908-033

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ARTHUR BROWN JR.				d / Department of Certificate of			Reg. No.	7 6	317.
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Baltimore, permit. Peges 1 a Department of He Important: If item any injury or othe pace.		Donation 5 ☐ Other (Special Signature of Funeral Service Lice	y) Fa	22. Nama and Add	ohial	2000 reenc f	Faint	tone	/A
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State of Maryland / Department of Health and Mental Hygien	9	428	18	

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Ruth Barnes Brashears December 31, 1999 4:00 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Crescent Cities Center Prince George's Riverdale 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 94 Yrs. 577-01-2680 Director Washington, Aug. 7, 1905 DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4409 East West Highway 20737 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Mantal Status efter 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry White House Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health and Mental Hygient Important: if item 27 is marked other that any injury or other traumatic avant, that page. 12 Telephone Operator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Joseph Brashears Elizabeth Yenney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia B. Suit - Cousin 311 North Glen Avenue, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/05/00 Suitland, Maryland 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee Pry 4739 Baltimore Avenue, Hyattsville, MD 20781 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONIA COMPLICATING PRACTURES disease or condition resulting in death) **Examiner** Examiner physician and s the burial-transit be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): attending 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown OSTEOPOROSIS by 24b. Were autopsy findings available prior to been si 24a. Was an autopsy Completed completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No Certification: To this After thi funerel 28d. Describe how injury occurred
SUBJECT FELL TO THE FLOOR. 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? or Attanding 1 Neturel 5 Panding Investigation after death.

Diractor: After d in by the fur 1 TYes 2 No 11/26/99 5:30 PM 2) Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide In Hallway 4409 East-West Highway, Riverdale, MD 124 hours a Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

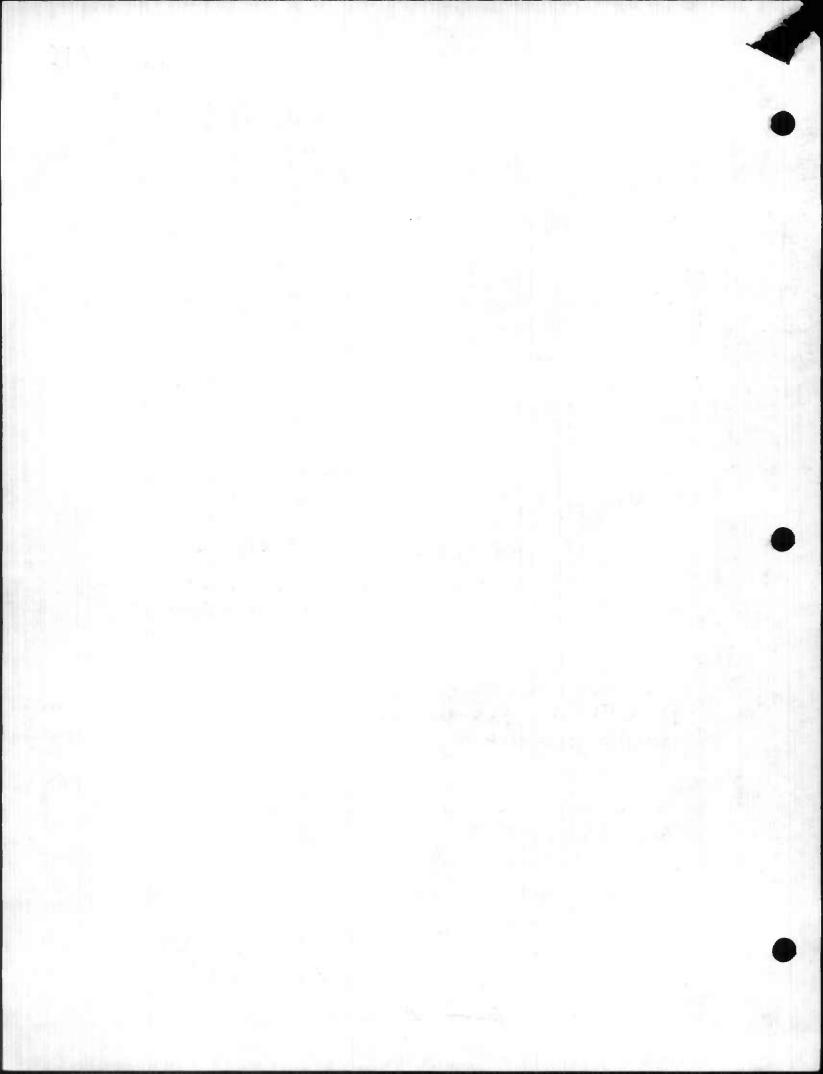
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) Within 2 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year) MUES D33954 January 5, 2000 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) Mario F. Golle, Jr., M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 4 2000 Registrar

DHMH 16 Ray 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneg Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month **Physician** Matilda 31, 1999 December 6:15 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors' Community Hospital Prince George's Lanham
If Under 24 Hrs. If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Fairfield, AL 37 422-90-5326 Director Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 💥 No Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10723 Kitchner Court 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puerlo Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ♣️ No If Yas, Giva 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Salesperson Retail Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be in travent of Health and Mental H tant: If Nem 27 is marked off jury or other traumatic even Robert Carter Lula Mae Baxer 19a. tntormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10723 Kitchner Ct. Mitchellville, MD 20721 Nathaniel Carter - Brother 20a. Method of Disposition

XYDBurial 2 □ Cremetion 3 □ Ramoval from Stata 20b Place of Disposition (Name of 20c. Location - City or Town, State George Washington Carver Cemetery 1/7/00 4 ☐ Donation 5 ☐ Othar (Specify) Birmingham, AL 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 21. Signatura di Funaral Sarvice Licensee do 5517 Vine Street, Alexandria, VA 22310 Pert 1. Enter the disease, or doublibations that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** FAILURE /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner MALIGNANT Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in deeth) Lest The law requires that the death certificate be execu Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Ninknown Completed by Division of Vital Records. 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No or Attending Physicien: Be 25. Was casa retarred to medicat axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 Anpatiant Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Watural 5 Panding 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director; At 2 Accidant investigation 6 Could not be detarmined 3 Suicide 28a. Place of tnjury - At homa, tarm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the best of axaminetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29a. Cartifiar edicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier le 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) (Tope) Read; #220; Bowe-MD-20716. 31. Data tiled (Month, Day, Year) 32. Registrar's Signatura State Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 1, 2020

					Certif	icate of	Death		Reg. No.	420	20
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		Patrick Duncan/ S					Road. Beth			51616, ZIP 0000	/
	-	20a. Method of Disposition	Л	20b. Place	of Disposition		wau. Deu	Date		City or Town, S	tate
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State of Maryland / Department of Health and Mental Hygiene 99 42821

				Ce	runcat	e or	Death		R	eg. No.	2 4	
4.1.	1. Decedent's Name (First, Mi	ddle, Last)							2. Date of Deal		Year	3. Time of Death
Physician /Medical		DELLA	FRAZ	IER					Jan		1999	8:50 AM
Examiner	4a Facility Neme (If not institu						4b. City, To	wn, or Lo	cation of Death		y of Death	
	Genesis El	derCare	- The	Pines			Ea	sto	n	Ta	albot	
Funeral	5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under		If Under	24 Hrs.	8 Date of Birth			lace (State or Foreign try)
Director	218-16-1650 Usual Residence of Decedent	1□ M 2 <b>X</b> ) I	80	Yrs.	Months	Days	Hours	Min.	Jan. 1,	1920	Penn	a.
show	10e. State 10b. Cou	nty	10c. (	City, Town or Lo	ocation						1	0d. Inside City Limits
5 0	Maryland Tal	bot	St	. Micha	ele							1 ☐ Yes 2 📉 No
or 28s-f short be notified Director	10e. Street and Number				10f. Zip	Code			1	Og. Citizen of	What Cour	itry?
r tems 23s or 28s-f show ites must be notified at Funeral Director	223 Madison A	we.			2	1663	3			U.S.	Α.	
hems 2 ner mu	11. Marital Status	12. Was D	ecedent Ever in	U,S. 13.	Was Deced	lent of I-	lispanic Ori	gin? (Spi	ecity Yes or No-		ce - Americ	
or its	1 Never Married 2 N 3 Widowed 4 Divorce	farried 1 TYes	Forces? es 2 Ko Give r Dates:		1 Yes, spec		Specify:	, Puerto	Rican, etc.)		ack, White, by: Whi	
ygiena. ser than "natural", or its it, tre Medical Exantra Completed by Fu	15. Dece	dent's Education		18a. Dece	dent's Usua	al Occup	ation			16b. Kind of B	Business/Inc	dustry
ple ple	(Specify only hig Elementary/Secondary (0-1)	thest grade complete	e (1-4or 5+)	(Give	kind of wo DO NOT u	rk done se retire	<i>during</i> mos d)	t of work	ng			
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d other event, Be C	17. Father's Name (First, Midd	lle, Last)						er's Name	(First, Middle, i		-	
If of Haelth and Mental Hygiena. If itam 27 is marked other than "natural, or other trsumatic svent, tra Medical East or other To Be Completed by	Harvey Newk	rirk					Flo	rend	e Bowma	n		
mari mari	19a. Informent's Name/Relation			19b. Maili	na Address	(Street			al Route Number		n. State. Zip	Code)
	Florence M. Ho	bod	Daughte									
Haelth am 27 other tr	20a. Method of Disposition	,ou		Place of Dispo	osition (Nar	ne of		. 171.		20c. Location		
nt: If its	1 Burial 2 Crematic			cemetery, cre								
tant	4 Donation 5 Other		Ca	pitol C		_			1999 I	over D	elawa	re
Department of Haelth important: If itam 27 any injury or other to once.	21. Signature of Funeral Servi	n EL	esoral	2 H		on I	E. Lec	naro	l Funera			and 21663
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C 00 =			1000						24e. Was e	n eutopsy	24b. W	ere autopsy findings
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 42822 Certificate of Death 1. Decedentis Name (First, Middle, Last) 2. Date of Death 3. Tima of Death ICHARD 4b. City. Town, or Location of Death 9. Birthplace (State or Foreign Country) If Under tf Under Social Security Number Age (In yrs. last birthday) Days Hours 10 M 20 F 65 215-32-2692 1934 Maryland December Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1143 - 44th Place, S.E. 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No HYes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2√ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 8th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Holly, Sr. John Forrest Mary Pearl Young 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes E. Holly (Spouse) 1143 - 44th Place, S.E., Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1) Burial 2 ☐ Cremetion 3 ☐ Removal from State Sacred Heart Cemetery 1/7/2000 Bushwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licental 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death prostate Cancer with Mets to bonn Immediate Cause (Final 2-11-5 disease or condition resulting in death) unkuown Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): unknown Fibrillation 4 years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 25 No 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be

**Funeral** 

Director

25a-f

8 marat be

Items :

the Maryland

filed within 72 hours after

Pages 1 and 2 ahould be in ment of Health and Mental H lant: If them 27 is marked off lury or other traumatic even

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Examiner Physician/Medical p Completed Be Certification: To

The law requires that the death certificate be executed and the 080 certificate or Attanding Physician: funeral director, this After death. ofter death Director: within 24 hours e Hospital

completely

2

State Registrar

edicai

1 ANatural

2 Accident

3 Suicide

29e. Cartifier

4 Homicide

(Check only one)

29b. Signeture and title of certifier Rointen Famuetan

5 Pending

investigation

6 Could not be determined

M.O

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 1)43446

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 201 Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 -7 3 -35

ROINTAN FARAHIFAR M.O. 9801 Georgia Ave Silver Spring 31. Date filed (Month, Day, Year)

MD 20902

This D. 2000 please to show

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month **Physician** 12 1630 Patricia King Hall /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 2□ F Months 219 01 9240 78 09/12/1921 Director England Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limita 28a-f ehon the Medical Examiner must be notified at MD Anne Arundel Crownsville 1 Yes 2 No Director 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 308 Longpoint Road 21032 USA 230 Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ☑ No If Yes, Give Year or Detea: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) | Heme 14. Raca - American Indian, 11. Marital Stetus Bleck, White, etc. filed within 72 hours after of Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White by 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Insurance Elementery/Secondary (0-12) College (1-4or 5+) Industry Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Glen King Lucia Groeneboom 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Bless, Jr. (son) 503 Monterey Street, Annapolis MD 21401 20b. Piece of Disposition (Name of cametery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremetion 3 ☐ Removel from Stete 12/31/99 Alexandria VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility
Advent Funeral & Cremation Services 2) KLC Annapolis, Maryland 21401 23a. Pert1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each limit of the cause Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner to (or as e consequence of) Examiner Artery oronary The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of physician s the burial Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or ea a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Peripheral Vascular 1□ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending 1 Yes 2 No deeth. Investigation 2 Accident 24 hours after deel Funerel Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide Hospital To the Hosp within 24 hou To the Fune completely fil 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besia of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and menner stated. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Jauria 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvatore Lauria 2003 Medical Parkway, Suite 100 Annapolis, MD 21401 32. Registrar's Signature 31. Dete filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

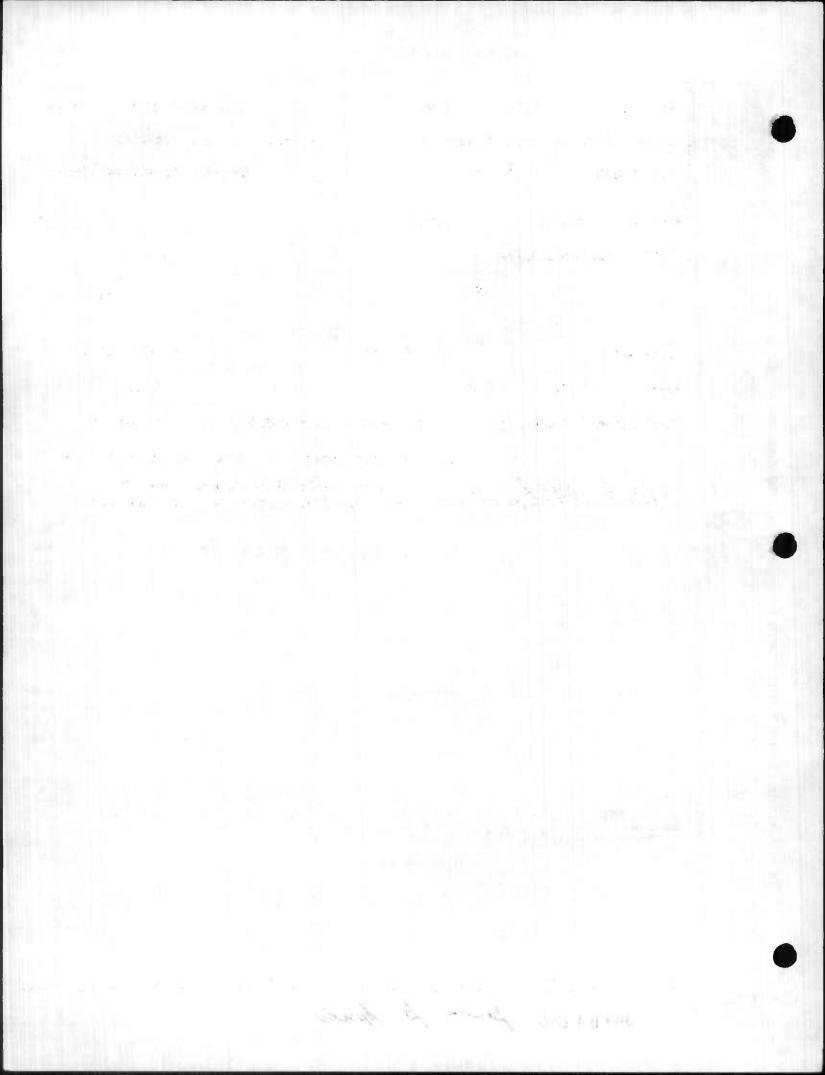
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AN D & 2000 - Secretary 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1

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State of Maryland / Department of Health and Mental Hygiene 99 42824

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Physician	Katherin		Ella		Irwin					December December	r 31.	1999	Year	2:00 AM
/Medical Examiner	4a Facility Name (It				********			4b. City, To	wn, or Lo	cation of Death	- T	County		2100 711
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Funeral Director	5. Sociel Security N 234-10-8		3. Sex 1 ☐ M 2 🖾 F		yrs. last birthde Yrs	Months	er 1 Year s Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da September	th ry, Year) r 26,	1911	9. Birthpla Country West	Virginia
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P.O. Box 68760. Vital To Division

JOHNSON

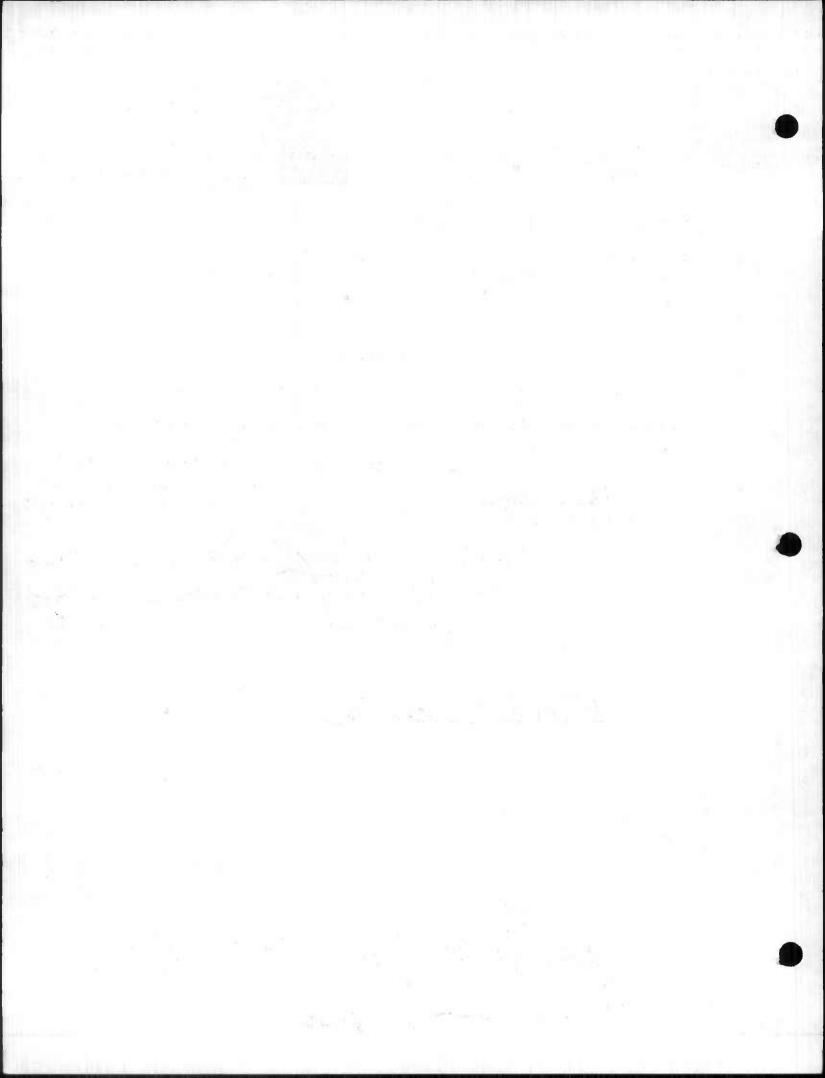
ELVA

KATIE

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** DECEMBER 30, 1999 8:00AM Katie Elva Johnson /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown
If Under 24 Hrs. 8. St. Mary's 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funerai** 1 M 2 F Months Days Hours Min. Yrs. 578-26-5972 95 Director Aug. 24, 1904Washington, D.C. Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 45713 Oregon Way 20653 Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ■ No Specify: 3 ■ Widowed 4 □ Divorced White The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondery (0-12) Coltege (1-4or 5+) N/A Housewife 7 is marked other treumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Katie Cummings Charles Briggs Emmons 19a. tnformant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) or other tree 45713 Oregon Way, Lexington Park, MD 20653 Laura Ann Redmond / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Depertment of important: If any injury or 4 Donetion 5 ☐ Other (Specify) 1/4/00 Charlotte Hall, MD All Faith Episcopal 22. Name and Address of Facility
Brinsfield Funeral Home, P.A. 21. Sighalum of 22955 Hollywood Road, Leonardtown, MD 20650-0279 Mar treaused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Intervat Between **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Physician/Medical noe of consequer use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate hes been signed by pege 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? N.A 2 No 1 ☐ Yes 2 No certificate Be funeral director. 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 topatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending Investigation 1 Naturet s efter death. 1 Yes 2 No the f 2 Accident 6 Could not be determined 3 ☐ Sulcide in by 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours filled The Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical completely (Check only one) the 29b. Signature end title o certifie 29c. License number 29d. Date signed (Month Day, Year) 30. Neme and address of cause of death (Item 23a) (Type, PTF P. JAMES JARBOY HOLLYWOOD, MD. 20636 31. Date tiled (Month Year) 32. Registrar's Signature State 04 Registra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 4 2 8 2 6 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) December 27, 1999 Bernard Joseph Johnson 8:46 AM 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 20929 Deerwood Park Drive Leonardtown St. Mary's Months Days Hours Min. 8. Data of Birth (Month, Pay, Year) September 3, 1945 Birthplaca (Stata or Foraign Country)
 Maryland 5. Sociel Security Number 7. Aga (In yrs. last birthday) 1 M 2 F 54 Yrs. 215-46-4132 Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20929 Deerwood Park Drive 20650 USA 14. Raca - American Indian, 12. Wes Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☐ No If Xes, Give Year or Datas: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th Grade Cable Splicer Telephone Company 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) John Bernard Johnson Cecelia Nea 1 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stata, Zip Coda) 20650 19a. Informant's Name/Ralationship (Type, Print) Linda Theresa Johnson (Spouse) 20929 Deerwood Park Drive, Leonardtown, Maryland 20b. Place of Disposition (Nama of cemetary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata Charles Memorial Gardens 12/30/1999 Leonardtown, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nema and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650
Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,
Approximately and the death of the Approximata fntarval Between Onsat and Death Immediata Causa (Final diseasa or condition rasulting in daath) + 150, la Dua to (or as a consequence of): Ormany a floros de Dua to (or as a consaquanca ot): 23b. Dfd tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy 1 Yas 2 KNo 1 ☐ Yas 2 ☐ No 26. Placa of Death (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death

**Physician** /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

signed by the e

bluods

his certificate has but director, page 2 s

this funeral

After

death.

To the Hospital or Attendir within 24 hours after death.
To the Funeral Diractor: At completaly lilled in by the fu

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Completed

Be

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Certification:

Medicai

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10e. Steta

Directo

Funeral

g

Completed

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelih end Mentel Hygiena. Important: if item 27 is merked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, in a Medical Examinet must be notified at enough.

Physician/Medical Examiner physician and the buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated avents resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Disbetes mellitur, type It

ty pertusion

25. Was casa rafarred to madical axaminar? 1 Yas 2 No

5 Panding invastigation

6 Could not be

28a. Data of Injury (Month, Day Year) 28a. Place of fnjury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

29a. Certifier (Check only one)

1 Natural 2 Accident

3 ☐ Suicida

4 ☐ Homicide

1 Certifying Physician: To the bast of my knowladge, daath occurred at tha tima, date and placa, and due to the causa(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. Licansa number

290. Signature and title of cartifian

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1.3.2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

John F. Fenwick, MD Leonardtown, Maryland 20650

State Registrar 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura JAN 0 4 2000

DHMH 16 Rsv 6/95

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mande l'aligne de la company d

ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	5		APORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	IMPORTANT: If item 28 is ma

AME	MEND ITEM: #30 PER V.R. G779 1-28-2000 WR. 99 42	2827
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
	REGISTRAR CERTIFICATE OF DEATH REG. NO.	
	MONTH DAY YEAR	3. TIME OF DEATH
	John Albert Lansberry Dec. 28, 1999	8:40 A. M
		LACE (State or Foreign
		st Virgin
	9e. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEA	
Œ		
16	Garrett County Memorial Hospital Oakland Garret	t
H	10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY
DIRECTOR	WV. Tucker Leadmine	LIMITS?
	200000000000000000000000000000000000000	YES 2 X NO
FUNERAL	106. STREET AND NUMBER  101. ZIP CODE  10g. CITIZEN OF WH	IAT COUNTRY?
9	Rt. 2 Box 283 26290 U.S.A	•
5	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Id. RACE - Black,  1 Never Marriad 2 Marriad Process 1 Yes 2 No If yes, apocify Cuben, Maxican, Puerto Ricen, etc.)	- American Indian, White, atc.
BY I	The region matters and a matters and a second a second and a second and a second and a second and a second an	
		te
Ш	15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION  (Specify only highest grade completed)  16b. KIND OF BUSINESS/INDUSTRY	
<u>-</u>	(Specify only highest grade completed)  (Give kind of work done during most of working life. Do NOT use refered.)  (Give kind of work done during most of working life. Do NOT use refered.)	
10	8 truck driver Limestone agg	revate
COMPLETED	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Meiden Surname)	
В		
100	10e INFORMANT'S NAME (Non-Print)	
2		
	Norma Jean Lansberry Rt. 2 Box 283 St. George, WV.26290	
	20a_METHOD OF DISPOSITION A Removal from State  20b. PLACE AND DATE OF DISPOSITION /Neme of Commettery, cremetory or other piece)  20c. LOCATION — City or Town	
	Rose Hill Cemetery 12/30/1999 Thomas	, WV.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Hinkle Funeral Home	
$\vdash$	P.O. Box 186 Davis, WV. 262	
	23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such ea cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.	Approximate interval Between
	IMMEDIATE CAUSE (Final	Onset and Death
	disease or condition Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
z	Cardiogenic Shock	
ERTIFICATION	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):	
🛚	Cerebral Vascular Accident	
ᇤ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):	+
1	resulting in death) LAST	
B		
	DART II Other significant and distance and the same significant and significan	WERE AUTOPSY FINDINGS
EDICAL	PERFORMED?	WAILABLE PRIOR TO COMPLETION OF CAUSE
	1 VES 2 NO	OF DEATH?
Σ		I YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:	
YS	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
표	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  28c. INJURY AT WORK?	
BY	12 Netural 5 Pending	
0	3 Suicide 286. PLACE OF INJURY — At home, farm, street, factory, office 286. LOCATION (Street and Number or Rural Ro	ute Number,
W I	4 Homicide detarmined	
LET	29a. CERTIFIER 1 CERTIFYING PHYSICIAN TO the hord of t	
물	(Check only One) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.	
COMPL	2 MEDICAL EXAMINES: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e)	and menner as stated.
ш	296. SIGNATURE AND TITLE OF CENTERS 29d. DATE SIGNED (I	Month, Day, Year)
0 8		7199
۲	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	1.
1 I	THOMAS G. JOHNSON 311 N. FOURTH ST. OAKLAND MD 21550	

32. REGISTRAR'S SIGNATURE

OAKLAND MD 21550

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 Amended Item #26, per Phy. Certificate of Death 1/10/2000, Carroll County, wj1 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth December 27 Helen G. **Physician** Logan 1999 10:40am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6504 Freedom Avenue Carroll Sykesville 8. Dete of Birth (Month, Day, Year) Feb. 20, 1919 If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 212 F 80 Yrs. 168 03 7527 Pa. Director Usuet Residence of Decadent the Maryland permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28s-f show says injury or other traumatic svent, tra Mester. 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore Baltimore 1 Yas 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2 Greenwood Rd. P.O.Box 5796 21208 U.S.A. Funeral 12. Wes Decedant Ever In U,S. Armed Forcas? 1 ☐ Yas 2 2 No If Yes, Give Yaer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Black, Whita, atc. 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specity: White by 3XWidowed 4 ☐ Divorced Completed 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Harry Brantner Trean Ritchie 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Gerard Barry Logan 2 Greenwood Rd. Baltimore, Md. 21208-5796 (Son) 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlat 2 Cremetion 3 Removel from Steta 12/31/99 Sykesville, Md. Springfield Cemetery -4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Favility ight Funeral Home & Chapel 21. Signature of Funerel Sarvice Licensee 23a. Part I. Enter ha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. P.O.Box 195 Sykesville, Md. 21784 Approximate Interval Between Onset and Deeth **Physician** Cardio respiratory arrest

Due to (or as e consequence of):

Brain tumor (glioblastoma multiform) /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician and the buriel-trensit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the cause of death? deteched signed by d 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evaileble prior to Completed 24a. Wes en eutopsy peed completion of cause of deeth? s certificate hes t director, page 2 s 1 Yes 25 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical exeminer?
1 ☐ Yes 275 No director, Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpetient this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation after death Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide in 24 hours the Funeral Director of the Funeral Direct Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.

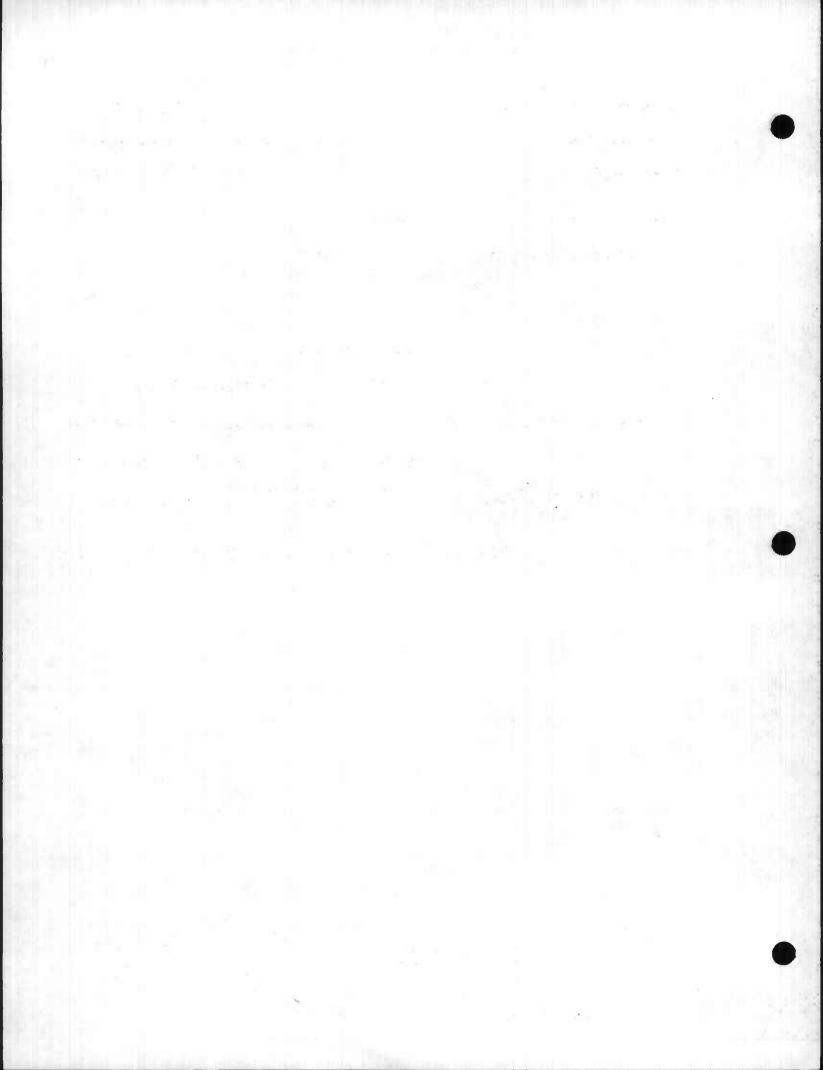
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end mennar stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 29d. Data signad (Month, Dey, Year) 29b. Signature and title of certifier 29c\_License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dept of Rad. One, Uning Md Hosp, 225 Greene St, Balt PRADIPP. AMIN MD 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signeture State JAN 1 0 2000 Registrar DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day **Physician** Kenesaw Mountain LANDIS 1999 Dec 30, 10:30 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 808 Geis Circle Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F Vrs 71 **Director** Sept. 5, 1928 Maryland 218-24-7936 Usual Residence of Decedant deeth with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. insida City Limits Show r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 Yas 2 No Director MD Garrett Oakland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 225 Fricks Crossing Road 21550 USA Funeral 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Welder 12th Truck Repair other 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) permit. Pegas 1 and 2 should be filk Department of Heelth and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic even PRES. Be Elvin Landis Mamie Florence Wright 19a, Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen Decker/Step-daughter 7260 Montevideo Road, Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/8/2000 Morgantown, WV Omega Crematory 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Stewart Funeral Home 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** conoma Vallour /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 88 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 9 24b. Were eutopsy findings available prior to Completed 24e. Was an autopsy completion of ceuse of death? page 2 1 ☐ Yas 2 🕱 No 1 ☐ Yes 2 ☐ No certificete Division of Vital or Attending Physician: director. 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1º 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Invastigation 2 Accident 6 Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated.

| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier completely (Check only one) within 2 \$ 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifian 0 2000 d cause of death (Item 2 ype, Print) 19th way Stebo 600 10 - ( 32. Registrat's Signature 31. Date filed (Month, Day, Year) State 2000 Registrar



ysician Iedical		Decedent's Nat Leona	me (First, Midd Fran		Mund	ly				2. Date of D	Reg. No.		3. Time of Death 10:10 pm	
aminer	4.0			n, give street and dventis			Cente	r		r Location of Dea	ilh 4c.	County of De	seth	
ıl r	5.	Social Security 227–74	Number	6. Sex 1 ☐ M 2 📉	7. Ag		last birthday) Yrs.	If Under 1 Yas Months Day			irth	3 9. 6	Birthplace (Stata or Foreign Virginia	
lor	10	sual Residence Da. State MD	of Decedent 10b. County			10c. City, Town or Location RockVille						10d. Inside City Limit		
The Park of the last	10	9701 M		Center 1	Dr.			10f. Zip Code 2085				izen of What	What Country?	
10a. State MD  10b. County MD  10c. Street and Number 9701 Medical Cen  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)  17. Fether's Nama (First, Middle, Last)  Albert W. Miller  19a. Informant's Neme/Reletionship (T)  Clara N. Layman  20a. Method of Disposition  1 XBurial 2 Cremation 3 F		1 Never Ma	Armed Forces?  1 Never Married 2 Married 1 Yes 2X No					Was Decedent of f Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pur Specify:	(Specify Yes or Narto Rican, etc.)	10-	mericen Indian, hita, alc. White		
		st grade comple	pleted)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker			upation e during most of w ed)	vorking 16b. Kind of Bush							
	17	17. Fether's Nama (First, Middle, Last) Albert W. Miller				L,		ame (First, Middle ca Zigle						
•	19a. Informant's Neme/Reletionship (Type Clara N. Layman	ship <i>(Type, Print)</i> I&N	)		19b. Mailir 2 Cha	ng Address (Stree arles Av	et and Number or re., Lura	Aural Route Num Y, Va.	ber, City o	or Town, State 835	e, Zip Code)			
20a. Method of Disposition  1 X Burial 2 Cremation 3 Rem  4 Donation 5 Other (Specify)			rom State	20b. Pl	lace of Dispo emetery, cren 1V111e	sition (Name of matory or other po UCC Cem	lace) 10.	Date 12/27/9	1		or Town, State le, Va.			
	2	1. Signature of F	Funeral Service	Licensee	/-	(Me		Name and Add	ress of Facility	_			mes, Inc. 22801	
	2	3a. Part1. Enter shock, or he	the disease, or eart feilure. List	complications to only one ceuse	hat ceused on each li	tane death	. Do not ent	er the mode of d	ying, such as card	ac or raspiratory	arrest,		Approximate Interval Between Onsel and Death	
	d	nmediete Cause iseese or condit issulting in death	ion	a (	or	onc	194	no & to	oud	NON	0		YRC	
	: 1					Due to (or	as e conseq	quence of):	ry	)COS				
	S	equentially list o	conditions,	b	a	rdi	as e consequence as a c	Pace	mak	Rex			YRS	
	a Ct	equentially list of any, leeding to ause. Enter Und ause (Disease at initiated even esulting in death	derlying or Injury	b	Hy	Due to (or	ac	pace university of the second	mak	Rex			YRS YRS	
-	C th	ause, Enter Und ause (Disease d at initiated even as ulting in death	derlying or Injury hts ) Last	b c d		Due to (or Due to (or	res a consequence as a consequence	pace university of the second	mak		d tobacco		YRS  YRS  ute to the causs of deat	
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	Pt	ause, Enter Unc ause (Disease c at initiated even scutting in death art II. Other algn  5. Was case refe	derlying or Injury its ) Last			Due to (or Due to (or	res a consequence as a consequence	pace of):		24a. Wa per	Yes 2 as an autopromed?  Yas 2	□ No 3□	ute to the cause of deati	
	P	ause, Enter Unc ause (Disease c at initiated even esuiting in death art II. Other sign  5. Was case refe axaminer?	derlying or Injury at the state of the state	Hospital:		Due to (or Due to (or ut not result not resu	res a consequence as a consequence	uence of):  uence of):  uence of):  nderlying ceuse (	26. Place of Dither: 4Æ Nursing	24a. Wa	Yes 2 as an autopromed?  Yas 2 yone) sidence	No 3 Desy 24	b. Were sutopsy findings available prior to completion of cause of death?	
Certification: To Be Completed by Physician/Medical Examiner	P	ause, Enter Und ause (Disease of nat initiated even southing in death, art II. Other sign  5. Was case refe axaminer? 1	erred to medical No ath	Hospital:  28a. Eggetion not be inhed 28e. F	to death b	Due to (or Due to (or ut not resu  pont 2 try y Year)	as a consequence of the conseque	uence of):  uence of):  uence of):  nderlying ceuse (	26. Place of Dither: 4. Nursing ury at ork? □ Yes 2 □ No	24a. Wa per 1	as an autoromed?  Yas 2  Yas 2  yone)  sidence (e)  show injure	Dosy 24  SNo  Glother (S)  Ty occurred	b. Were sutopsy findings available prior to completion of cause of death?	
Be Completed by Physician/Medical	25 27 25 25 25 25 25 25 25 25 25 25 25 25 25	ause, Enter Uncause (Disease cause (Disease cast initiated even esulting in death art II. Other sign  5. Was case refe axaminer?  1 Yas 2 7  7. Menner of Des 1 7  7. Netural 2 7  8. Accident 3 Suicide	erred to medica  No ath  Signature  Oracle  Or	Hospital:  28a. Eg gation not be ined 28e. F b	to death b	Due to (or Due to (or Due to (or Due to (or Due to (or Due to (or Due to (or Due to (or Due to (or Due to (or	as a consequence of the conseque	nuence of):  uence of):  uence of):  nuence	26. Place of Control Nursing ury at ork?  Yes 2 No e	24a. Wapel  24a. Wapel  1 Ceath (Check only)  Homa 5 Re  28d. Describe  28f. Location City or T	Yes 2 as an autorformed?  Yas 2 y one) sidence e how injur (Street an own, State e cause(s)	DSNo 3 DSNo 24  DSNo 6 Dother (Sny occurred and Number or a)	b. Were sutopsy findings available prior to completion of cause of death?  1 Yes 2 No	

DHMH 16 Rev 6/95

ORIGINAL

SEBTONE PROPERTY. SERVICE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Carol Welteroth Marvin 30, 1999 9:05 PM December /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Davidsonville 2003 Gresham Lane 7. Age (In yrs. last birthday) 45 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) West Virginia 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Ye **Funeral** Months Deys Hours 1 M X F Sept 10,1954 **Director** 139-50-8688 Usuel Residence of Deceden with the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Manyler and cleath and Mental Hyglena.

Intit if tam 27 Is marked other than "naturel", or items 23s or 23s-f show my or other traumatic event, the Medical Example modified any or other traumatic event, the Medical Example modified any or other traumatic event, the Medical Example modified and other traumatic event, the Medical Example modified and other traumatic event, the Medical Example modified and other traumatic events. 1 Yes X No Davidsonville MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21035 2003 Gresham Lane United States Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 \( \text{Yes} \)

2 \( \text{No} \)

No \( Specify: \) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Meritel Stetus 1 ☐ Yes XX No If Yes, Give Yeer or Dates: 1 Never Married Married Baltimore, Maryland 21215-0020 Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ptic (Specify only highest grede completed) Elementery/Secondary (0-12) Cellege (1-4or 5+) St. Mary's of the Assum-Principal 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Carl R. Welteroth Alice Klingenberger 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 2003 Gresham Lane, Davidsonville, Maryland 21035 Charels R. Marvin, Jr (Husband) 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) Jan 4, 2000 20e. Method of Disposition 20c. Location - City or Town, Stete PBurial 2 Cremetion 3 Removel from State permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signetura of Funerel Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset end Deeth **Physician** Metastatic Reval (ell Carcino Me /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit requires that the death certificete be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): 98 980 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underiving ceuse given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably Y ☐ Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Was an autopay Completed page 2 1 Yes XX No 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medicel exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 3 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mapner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: After 5 Pending 1 ☐ Yes ZZNo death. investigation 2 Accident efter death Director: 28f. Location (Street and Number or Rurel Route Number City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, filled in by Hospital 24 hours e 24 hours To the Hosp within 24 ho To the Fune completely fi 10

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number

D17207

00 01

30. Name and address of person who completed cause of Baleth (Nam 23e) (Type, Print)
David S. Ettinger, MD, 600 N. Wolfe St., 147, Baltimore, MD 21287

State Registrar

Medical

31. Dete filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene 9 4 2832

	1. Decedent'a Name (First, Middle, Last	0)		O' timodic	of Death	2. Date of D		3. Time of Death	
Physician		Manz				De cembe	Day Year 30 1999	ar	
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Tor	wn, or Location of Dea			
LXaiiiiici	Anne Arundel Me	dical Cent	ter		Anna	polis	Anne A	Arundel	
uneral rector	5. Social Security Number 6. Se 0 77-18-9804 1D Usual Residence of Decedent	X 7. Age	75 Yrs.   Worths   Deys   Hours   Min.   April 20, 1924				irth 9. 20,1924 1	Birthplace (State or Fore Country) New York	
ě u	10a. State 10b. County 10c. City, Town or Location							10d. Inside City Lim	
here 23e or 25e-f show her man be notified at funeral Director	MD Anne Arundel Annapolis						V∕O Yes		
1 2 2	10e. Street and Number			101. Zip Code			10g. Citizen of What Country?		
thems 23e or 25e-fe obserment be notified Funeral Director	12 Bristol Drive			21401		USA			
1	11. Marital Status	12. Was Decedent E Armed Forces?	2. Was Decedent Ever in U.S. 13. Was Decedent If Yes, specify (			in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Race - A	merican Indian, /hite, etc.	
by B	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		0	1 ☐ Yes 2 ₹☐ No Specify:				White	
r, the Medical Completed	15. Decedent's Edu (Specify only highest grad		16a. De	cedent's Usual ve kind of work	Occupation done during most retired)	of working	16b. Kind of Busine	ss/Industry	
the Man	Elementary/Secondary (0-12)	College (1-4or 54	) iii				Own home		
P. C.	12 17. Father's Name (First, Middle, Last)		Homemake			r's Nama (First, Middl		ile	
D M							е, мацен эипапте)		
D 0	George Garrett  19a. Informant's Name/Relationship (7)	vne Printl	106, 12	iling Address		Corbett	ber, City or Town, Stat	e Zin Codel	
at the unit	Edwin H. Manz / hu								
other tr	20a. Method of Disposition	isband	20b. Place of Dis	Bristol Sposition (Name	e of	Annapolis	20c. Location - City		
# 15 E	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)			rematory or oth		1 1 2 00		MD	
The Table	21. Signature of Furnitual Service Licens		Hillcres			lens 1-3-00			
any l	P C C	Vone	00 1					cal Home, In	
	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused to						Approximata Interval Between	
sician	arout, or front failure. List only o	NO CAUSE OF BACIT IN			,			Onset and Death	
edical	Immediate Cause (Final disease or condition	/	MICACI	rebro	/ B/G	<i>=U</i>		1994	
miner	resulting in death)		Due to (or as a cons				1		
a or		b							
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director,	examiner?	Hospital: 1 Inpatien	t 2 ER/Outpat	inat 20 DO	Other	of Death (Check only	sidence 6 Other (5	Pagaihal	
2 2	27. Manney of Death	28a. Date of Injury (Month, Day			lc. Injury at Work?		how injury occurred	эрөспу)	
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To the Funeral Directo completely filled in by th Medical Certific			examination and/or				e cause(s) and manne a, date and place, and		
Me the	29b. Signature and title of certifier	es to the state	ou.	29c.	License number		29d. Date signed (M	onth, Day, Year)	
<b>≥</b> 8	Va VIONO DE	a m			38445		Dec 30	1999	
	20. Name and address of names of	ampleted cause of de-	ath (Nam 93a) /T-		0	1 00			
	30. Name and address of person who co	CIC S	1 (7 5 Jan	- Juni	HOOM	20/1 M/	21401		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day 6 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death System BALTIMORE V. of MAryland mas BALTIMOR 1ca If Undar 24 Hrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 3-1-19. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 25 F 220-32-8400 1938 VIRGINIA 61 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits DELA. KENT DOVER 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 200 NORWICH WAY 19901 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian Black, White, atc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 10th 18. Mother's Nama (First, Middle, Maiden Sumama)
LOLA MAE TAYLOR 17. Father's Nama (First, Middle, Last) GEORGE COPES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULETTE BOWE 200 NORWICH WAY, DOVER DELAWARE 19901 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Deurial 2 □ Cremation 3 □ Removal from State MILFORD DE. 12-31-ODD FELLOW CEMETARY 4 ☐ Donation 5 ☐ Other (Specify) YOUNG'S G'S FUNERAL HOMES IN NORTH ST.MILFORD DE. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility 19963 Lorence 23a. Part1. Enter the disease, or complications that caused the death. Death enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaen Onset and Death Immediata Causa (Final mater disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Umknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yes 2 No 25. Was casa referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Department 3 DOA 2 ☐ ER/Outpatient 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d, Describe how injury occurred 28b. Tima of 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

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Department of Health and Mental Hy important: If New 27 is marked other any injury or other the

altimore, Maryland 21215-0020

Box 68760

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physician and s the buriel-transit USB 85 signed by the a Deen cate hes certificate director, 80 10 this Medical Certification: After

Physician/Medical p Completed

The lew requires that the death certificate be executed for Attending Physician: after death. To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the funeral completely fi

> State Registrar

31. Data filed (Month, Gax You

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signatura and titla of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c Licensa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

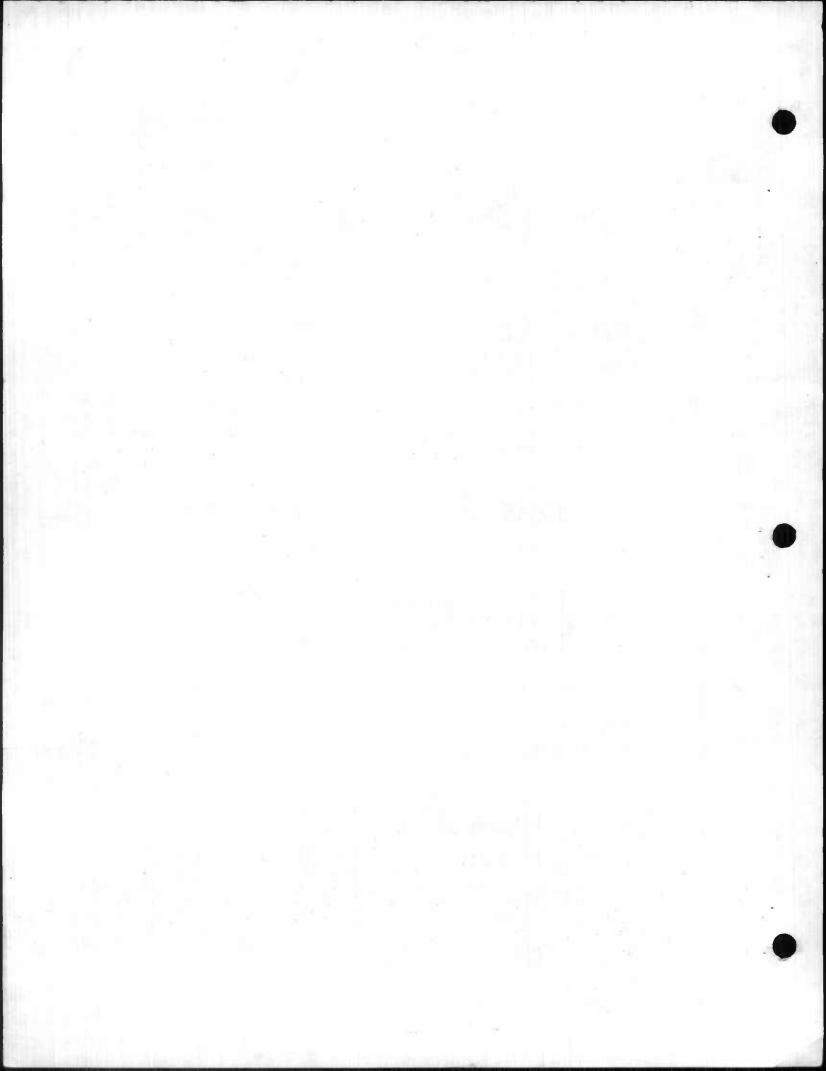
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Name and address of cause of death (Item 23a) (Type, Print) 00

6 Could not be

South Green 5%.

32. Registrar's Signatura



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Funeral	Holy Cross  5. Social Security Number	6. Sex	7. Ag	e (In yrs. last b		f Under 1 Year	Silver S	8. Date of B	Montgo		ace (State or Foreign		
Director	576-90-7643	1 🔀 M 2	OF	35	Yrs.	fonths Days	Hours Min.	March	25.1964	Washi	ace (State or Foreign ry) .ngton, D.C		
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Dir be	10e. Street and Number					10f. Zip Code	0710		10g. Citizen of What Country? United States				
have 23s or 28e-f show ner must be notified at uneral Director	615 63rd P		s Decedent I	Ever in II S	13 Wa		20743 Hispanic Orlgin? (S	Specify Yes or N					
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fical fical		edent's Education	leted)	166	a. Deceden	t's Usual Occup	pation during most of wo	deina	16b. Kind of B	usiness/Indu	ustry		
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, or .	1 Buriel 2 ☐ Cremate 4 ☐ Donation 5 ☐ Other		t from State			ory or other place morial		1/4/00	Landov	er. M	d.		
any injur	21. Signature of Furgeral Ser		1 6		A	eme and Addre	ess of Facility  r S. Pop  1boro Pi	e Funer	al Homes	WA	20747		
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/	20. Name and address of per	cher	d cause of de	2 30 7	Type, Pri	n)	old Rd	Whee	Jan 1	ub -	28, 1999		
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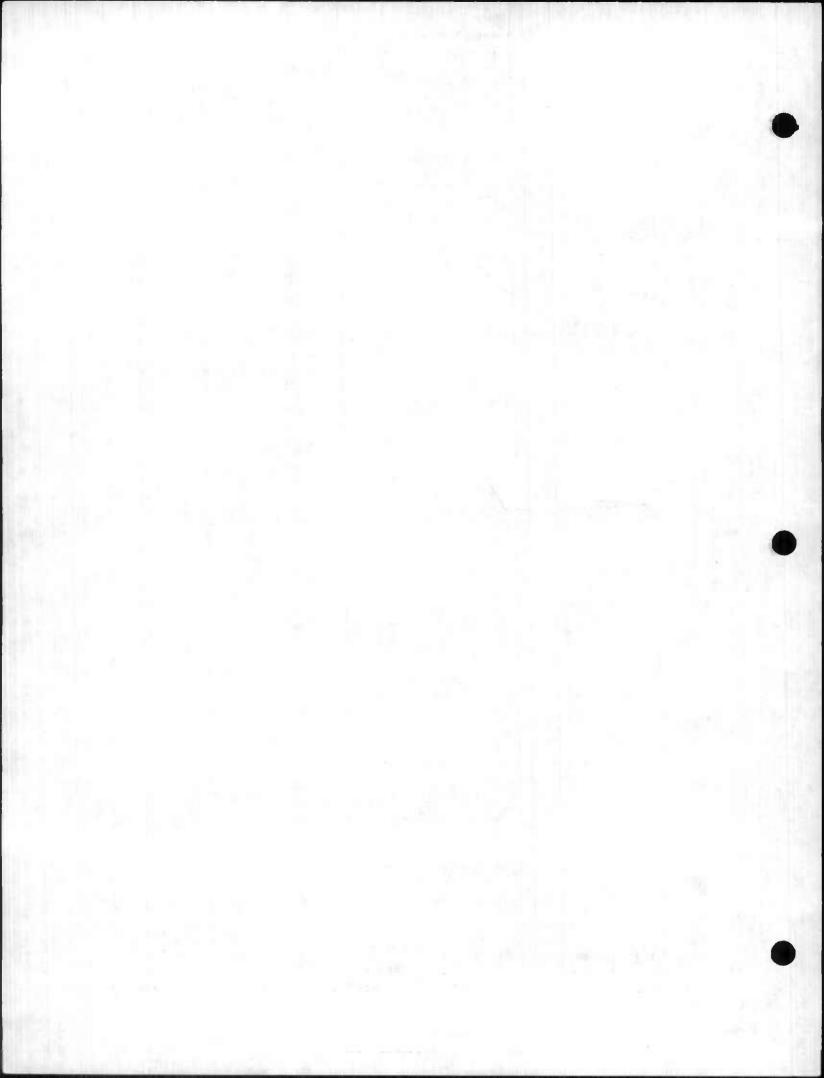
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Physiclan AMY SMITH 0330 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Catonsville Baltimore Catonsville Commons Nursing Home 7. Age (In yrs. last birthday). 80 Yrs. If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Dete of Birth Month, Pay, Year) 02/04/1919 9. Birthplace (State or Foreign Country) Michigan **Funeral** Days 1 M 2 TF Months Hours 357 07 2309 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits "natural", or items 23s or 28s-f shoved call Examiner must be not the at MD Howard Ellicott City Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 North Ridge Road #803 21043 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Deles: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Biack, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours effer of Department of Haaith end Mental Hygiene. Important: if Item 27 Is merked other than "naturel", or her important: if Item 27 Is merked other than "naturel", or her any Injury or other traumatic event, the Medical Examines any Injury or other traumatic event, the Medical Examines 2006s. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Eulalie Greene Vernon Haag 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4103 Beechwood Road, University Park MD 20782 Sandra J. Gill (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Remove from State Metropolitan Crematory 12/31/99 Alexandria VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Advent Funeral & Cremation Services Wilhel me Now Ther Mel alui Falls Church VA 22046 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medicai Examiner Examine The law requires thet the death certificete be axecuted physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medicai that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Sepsis ğ 24b. Were autopsy findings aveilable prior to completion of cause of death? Advanced Alzeiner's type Denote performed? Completed 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 Neturel 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a Hospital 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. Medicai 29e. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TURAKHIA, MD. 1009, Frederick Rd. CATONSVILLE, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2000

**DHMH 16 Rev 6/95** 

Registrar

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 4 2837

Certificate of Death

		Certificate of	Death	Reg. No.					
F	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath 3. Tima of Death					
Physician Medical	Shirley Mae	Wose	December						
Examiner	4a Fecility Name (If not institution, give street and number) St. Mary's Nursing Center		4b. City, Town, or Location of Deat Leonard town	4c. County of Death St. Mary's					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 1 M 2) F 59	yrs. last birthdey) If Under 1 Year Months Days	Hours Min. 8. Dete of Bir (Month, De	th y, Year) 9. Birthplece (Stete or Foreign Country) New York					
with the Maryland a or 28a-f show be notified at	Usuel Residence of Decedent  10e. State 10b. County 10c		10d. Inside City Limits 1 ☐ Yes 2 ☑ No						
vith the Maryla or 28a-f sho be not/led at	Maryland   St. Mary's   C	alifornia		10g. Citizen of Whet Country?					
death with	23429 Kingston Creek Road	2061		USA					
020 urs after st., or he	11. Marital Stetus  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Dates:	in U,S.  13. Was Decedent of H If Yes, specify Cubi  1  Yes 2 No	lispenic Orlgin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indien, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondery (0-12)  College (1-4or 5+)	16e. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working d)	16b. Kind of Business/Industry					
	12th Grade	Secretary		Retail Sales					
Bud the fill dott	17. Father's Neme (First, Middle, Last) Francis Tyrrell		18. Mother's Neme (First, Middle Vivian	(Maiden Sumeme)  leston					
20 20	19a. Informant's Name/Relationship (Type, Print) Forest Lee Wose	23429 Kingsto		er, City or Town, State, Zip Coda) 20619 Nifornia, Maryland					
0 0 0 -	TXI Burial 2 Cremation 3 CHemoval from State	Ob. Place of Disposition (Name of cometery, cremetory or other pletcharles Memorial Gard		20c. Location - City or Town, State  Deconardtown, Maryland					
Baltimo	21. Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility	l Home, P.A. Maryland 20650					
	23e. Part1. Enter the disease, or complications that caused the shock, or beart failure. List only one cause on each line.								
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Box ath certification of the c	d								
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ecord ew requir us been si 2 should				an autopsy primed?  24b. Were eutopsy findings available prior to completion of cause of deeth?					
= F # 8 0			10	Yes 2 No 1 Yes 2 No					
of Vital Re Physician: The I this certificate har ral director, page	25. Was case referred to medical examiner?  Hospitei: Hospitei:	Ott	26. Place of Death (Check only						
Ming Ph. After thi funeral	27, Menner of Death  1 Natural 5 Pending (Month, Day Yea	28b. Time of linjury Wo	4 Nursing Home 5 Hesi	dence 6 ☐Other (Specify) how Injury occurred					
Division or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	2 Cuiside 6 Could not be	At home, ferm, street, fectory, office		Street and Number or Rural Route Number, wn, Stete)					
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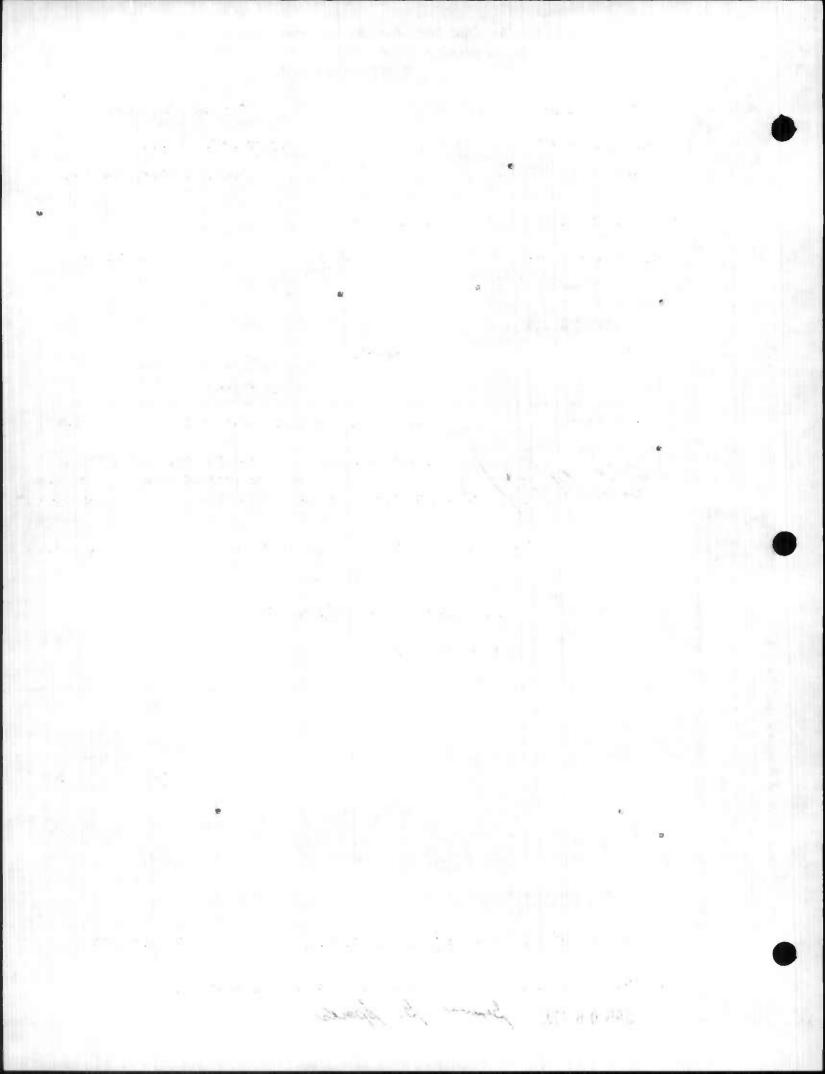
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State of Maryland / Department of Health and Mental Hygiene Q Q

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	/Medic	_							4b. City, Town, o					
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	Funeral		5. Social Sacurity Number	6. 8	Sex 7. A	ga (in yrs. last b	Mont		Hours Mir		rth ay, Year)	9. Birthp	lace (Sta try)	ta or Foreign
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	28a-f	Director	10e. Street and Number				-	Zip Coda			10g. Citizen of	What Cour	try?	
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** JOHN WOOD Dec. 30 10:20 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Data of Birth (Month, Day, Year) May 23, 1899 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 216-32-0754 100 Rhode Island Director Usual Residence of Decedan 10a. Stata 10b. County 10c City Town or Location 10d. Inside City Limits 28a-1 show must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2204 River Cresent Drive Nama 23a 21401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Nevar Married 2 ☐ Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if them 27 is marked other tha any Injury or other traumatic other tha and Metallurgist Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John W. Wood Ella Weaver 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Bettie A. Wood/ Daughter inlaw 2204 River Cresent Dr. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 D Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Bluff Cemetery 01-04-00 Annapolis, Maryland sature of Funeral Service Liefs 22. Neme and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 Part1. Enter the disease, or complication that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one of use on each line. Approximeta Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final STREPTOCOCCAL SEPSIS CYAG P diseasa or condition resulting in death) Examiner Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to Immadiete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai the Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown NONS by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 20 No 2□ No certificate Division of Vital or Attending Physician: director. 25. Was case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Dete of Injury (Month, Dev Year) Natural 2 Accident To the Hospital to mind within 24 hours after death.

To the Funeral Director: After mindle of the funeral by the funeral arts. 5 Panding 1 ☐ Yes 2 ☐ No investigation NIA 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one 29b. Signature and this of continue 29c. License number 29d. Date signed (Month, Day, Year) 12-30-55 D39637 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) ANNE ARCHOEL MEDICAL CENTR ANNAROLL DOUGLAS S MITCHELL 31. Date filed (Month, Dey, Year) Registrar's Signature 32 State JAN 0 4 2000

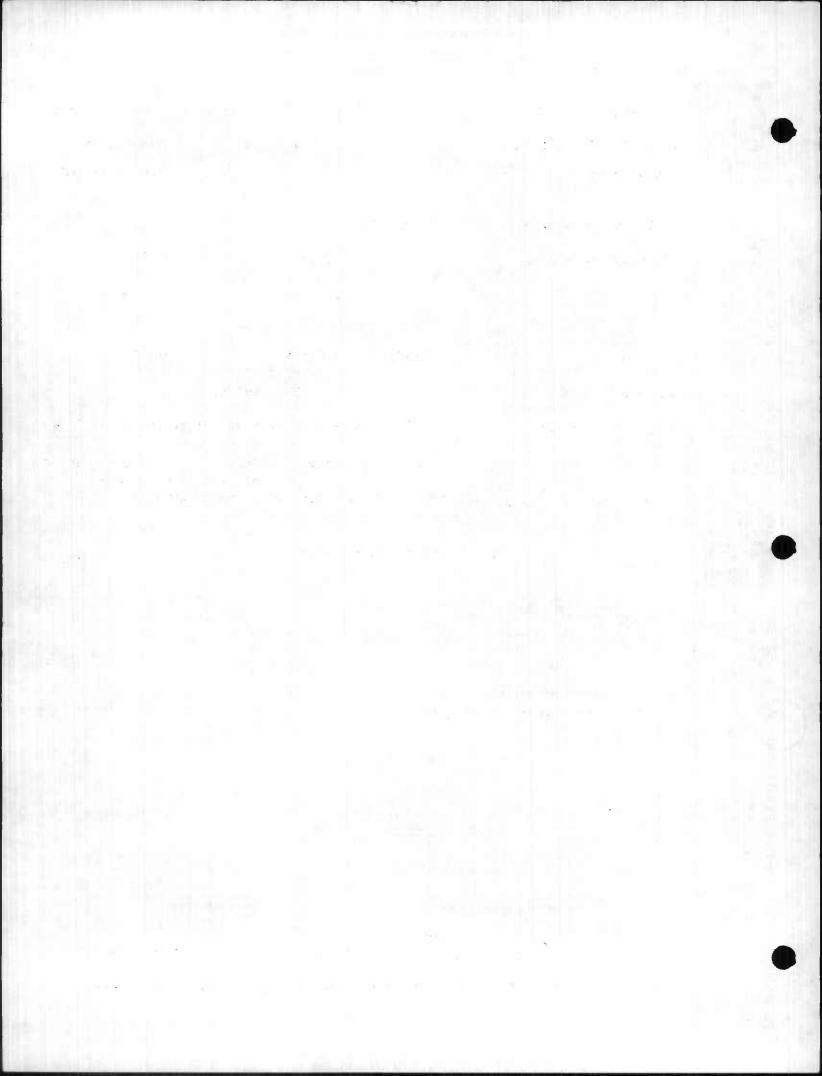
**DHMH 16 Rev 6/95** 

Registrar

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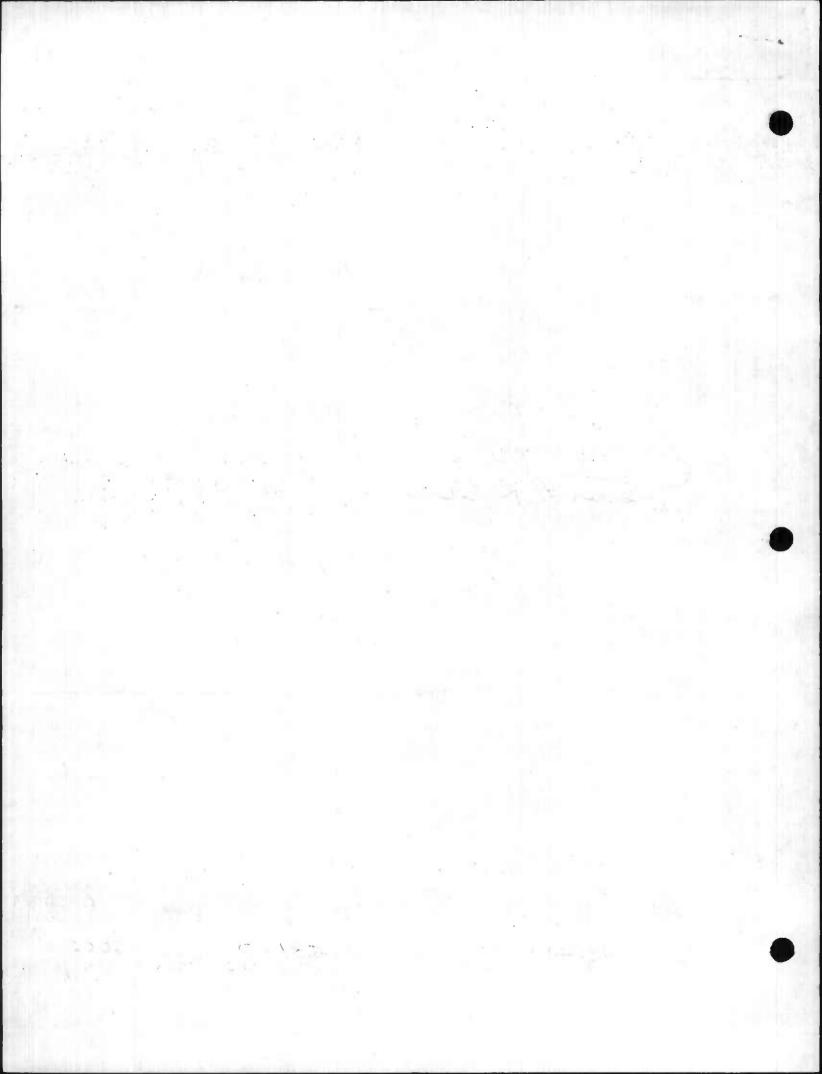
led	Item#2 perPhyG780 2/3/2		Certifica				Reg. No.	42840	
ian	1. Decedent's Name (First, Middle, Las  June Angela GREEN					2. Date of De Month	Day1999 Y		n
ical ner	4e Facility Neme (If not Institution, give				4b. City, Town, or				1.0
ner	Clearview Nursing 5. Social Security Number 6. Se	Home	ast birthdey) If Und Yrs.	der 1 Year s Days	Hagersto If Under 24 Hrs Hours Min.	8. Date of Bi	rth ay, Year)	ngton 9. Birthplace (State or Foreign Country) Maryland	n
	Usual Residence of Decedent								
	10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits	
Director	Maryland Washing	ton	Hagersto	WN Zip Code			10g. Citizen of Wh	M☐ Yes 2☐ No	
	700 16 1 1 4				7/0				
Funeral	729 Maryland Aven	12. Wes Decedent Ever in U,5	S 13 Was De		L740	Specify Yes or N	U.S.A	American Indien,	
D.	1 Never Merried 2 Merried 3 X Widowed 4 Divorced	Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		ecify Cub 2∏ No	dispanic Origin? (Sen, Mexican, Puer Specify:	to Ricen, etc.)		White, etc. White	
Completed	15. Decedent's Ed (Specify only highest gred Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)		work done use retire	during most of wo d)	rking	16b. Kind of Busi	ness/industry	
	12	0	Credit De	pt. (		(Floor) Adiabati	Retail		
Be	17. Fether's Name (First, Middle, Last)				15. Molhers Na	me ( <i>r-irst, Middle</i>	a, Maiden Sumeme)		
2	Raymond N. Fowler				Emma I				
	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Addre	ss (Street	end Number or A	ural Route Numl	per, City or Town, St	tate, Zip Code)	
	Gary Greene - Son				r Drive			Md. 21740	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	0.0	lace of Disposition (formatery, cremetory)	ieme of r other ple	ce)	Date	20c. Location - C	ity or Town, State	
	4 Donation 5 Other (Specify		est Haven	Ceme	tery 1	4/2000	Hagersto	wn, Maryland	
3	21. Signature of Funesal Service Licens		22. Name	and Addre	ess of Facility		Funeral H		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death						Approximate Intervel Between	
	Immediate Cause (Final disease or condition resulting in death)	Acute Br	onchopne	umor	nia			Onset and Death 4 Days	
ner		Due to (or	r as a consequence of	of):					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):							
Medical	Cause (Disease or Injury that Initiated events resulting In death) Last	Due to (or as a consequence of):							
an/i		d						1	
sici	Part II. Other significant conditions co	ntributing to death but not resu	ulting In the underlyin	g ceuse gi	ven in Pert I.	23b. Dio	tobacco usa conti	ribute to the cause of death	?
by Physician/M	Dementia o	f Alzheimer'	s Type			1	] Yes 2□ No 3	3 Probably 4 Unknow	rn
Completed b							s an autopsy omed?	24b. Were autopsy findings evailable prior to completion of cause of death?	
Eo						1 🗆	Yes 200 No	1 Yes 2 No	
	25. Was cese referred to medicel				26 Place of De	ath (Check only	one)		
o Be	examiner?	Hospital: 1   Inpatient 2	ER/Outpatient 3	DOA OI	hor:		sidence 6 Other	(Specify)	
tion: T	27. Manner of Death  1 DNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		1	how injury occurred	1 1 - 27	
Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fac	ory, office			(Street end Number own, Stete)	r or Rural Route Number,	
edical		sician: To the best of my know iner: On the basis of examinati and menner stated.							
Me	29b. Signature and title of certifier	/ 1		29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
	(d	uff fun h		Do: 7	857		Dec. 2	29, 1999	
	30. Name and address of person who c			na Ri	oad Han	erstown	n, Md. 2	21740	
ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	lure	pork	_		-		
rar	DEC 2 0 199	y A Property	41	11 Page 16	. /				



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42841

			,	Certifica	te of	Death	Re	g. No.	46	2041	
	1. Decedent's Name (First, Min	2. Date of Death		3.	Time of Death						
Physician	Jeffrey Ro	bert Goell					Novembe	r 26.199	9 7	:45 P.M.	
/Medical Examiner	4e Fecility Name (If not institu	tion, give street and numb	er)			4b. City, Town, or	Location of Death	4c. County of			
	51 E. Patr	ick St.				Frederic	ck	Frede	erick		
Funeral Director	5. Sociel Security Number 388-56-9463	6. Sex 11 M 2 F 7.	Age (In yrs. last bi	Yrs. If Under Months	er 1 Year B Days	If Under 24 Hrs Hours Min		1953 U	9. Birthplace Country)	(State or Foreign	
v	Usual Residence of Decedent										
ryter test	10a. State 10b. Cour		10c. City, Tow							Inside City Limits	
the Maryla 28a-f sho notified at	Md. Fre	ederick		Frederi	.ck			1)() Yes			
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code 10g. Citizen of What 0							
	51 E. Patri	ick St.			2170	1	-50	u.s.A.			
d within 72 hours after death of the standard of thems 23a the Madical Examiner must completed by Funeral	11. Merital Status  1 Never Married 2 Nover 3 Widowed 4 Divorce	Armed Forces?  1 Yes 2 No  1 Yes Give			edent of hearify Cub		Specify Yes or No- to Rican, etc.)	Black,	American Ir White, etc. White		
2 ho		lent's Education	16a	Decedent's Us	ual Occup	pation	. 1	6b. Kind of Busi	ness/Industr	у	
Die de	(Specify only hig Elementary/Secondary (0-12	or 5+)	(Give kind of w life. DO NOT	ork done use retire	during most of wo d)	rking					
the property of	Listing in the state of the sta	4 Edi						Trade	Assoc	iation	
be filed within 72 ho tal Hygiens. I other than "natura event, the Medical. Be Completed	17. Father's Neme (First, Midd	le, Last)				18. Mother's Na	me (First, Middle, M	leiden Sumame)			
12 should be file 12 should be file 12 should be file 13 marked oth 14 marked oth 70 Be (	Robert W. C	Goell				Lave	rne Lauer				
of Self	19a. Informent's Name/Relation	onship (Type, Print)	198	. Meiling Addres	ss (Street	and Number or R	ural Route Number,	City or Town, S	tate, Zip Coc	de)	
- 5 - 5 - C	Caroline M. (	Goell Wife	) 5	1 E. Pa	tric	k St. Fr	ederick, M	d. 2170	1		
emit. Pages 1 a Jepartment of Hea Troctant: If Nem Try Injury or othe TSS.	20a. Method of Disposition  1 Burjel 2 Kremation 3 Remove from Status  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Manual Company of Town,										
Parties P	4 Donation 5 Other	16	micens			ess of Facility				a.	
100	monni	2 N	tour			ral Home	12525 Bru	adbury A	lue.		
CALL	23a. Pert1. Enter the disease,	or complications that caus	sed the death. Do	not enter the mo	de of dyir	ng, such es cardia	Smithsbu	rg, Ma. 2	Apr	proximete	
Physician	shock, or heert failure. L	ist only one cause on eed		,		^			Inte On:	erval Between set and Death	
/ /Medical	Immediate Cause (Final ACLUE)										
Examiner	disease or condition resulting in death)  a. CHICLOPULWAY JANUY									0/6	
	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
unsit min	1-11	b. Hace	MANDA	14000	10	of wa	round !	ringo	7		
an and all tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es a	consequence of	" (				1		
flicate be executed g physician and as the burist-transit	Cause (Disease or Injury that initiated events	C	Duran faranci						1		
ificate phy as the	resulting in death) Lest		Due to (or es a	consequence of	):				1		
	2000	d									
attendin Ifor usa							1				
es that the death cer igned by the attendin be detached for usa by Physician/N	Pert tt. Other significant cond	Itlons contributing to deati	h but not resulting i	n the underlying	cause giv	ven in Part t.	23b. Did tobacco use contribute to the cause of death?				
that that ded b							1 U Ye	\$ 22 No ∶	Probabi	y 4 Unknow	
The law requires that the death certains bas been signed by the attendir page 2 should be detached for usa Completed by PhysicianA							24a. Wes ar	autoosy	24b. Were a	autopsy findings	
v require been sit should t							perform	ed?	evailab	ole prior to etion of cause th?	
has b								/	of deat	h?	
Cate he cate he cate he							1□ Ye	s 2/2/No	1□ Ye	s 2 No	
entifi ector	25. Was case referred to medi examiner?				100		eth (Check only one	9)			
- K 50 D	1 Yes 20 No	Hospital:			NA		Home 5 Reside				
fier t	27. Manner of Death  12 Naturel 5 Pen	ding 28a. Dete of I		Time of Injury	28c. Inju		28d. Describe ho	w injury occurred	1		
endii or: A the fu	2 Accident inve	stigetion		М	1 🗆	Yes 2 □ No					
tal or Attending Physics after death.  It Director: After this led in by the funeral death.  Certification: To	3 Suicide 6 Cou	mined 288. Plece of	Injury - At home, fe etc. (Specify)	erm, street, fecto	ory, office		28f. Location (Str City or Town		or Rural Ro	oute Number,	
To the Hospital or Attending Physicial 24 hours after death within 24 hours after death completely filled in by the funeral Completely filled in by the funeral Medical Certification:	(Check only 2 Medic	ying Physician: To the be al Examiner: On the basis	st of my knowledge of examination an	e, death occurre	d et the ti	me, date and place	e, end due to the ca	use(s) and men	ner as stated	d. cause(s)	
the the popular	one)	and manner	stated.								
To the To the Com	29b. Signeture end title of certi					se number		d. Date signed			
110	1/4/11	MILL		1	UD	5317	7 7	AV 14	100	00	
	30. Neme and address of person		of death (Item 23a)	(Type, Print)	Suhn	V WATE	7 7 1414 9 e, MP.	707 M	elitre	102.	
Cana	31. Dete filed (Month, Day, Yea	ar) 32 Regi	strar's Signature		170	CIL VIII-	4 1011				
State Registrar	EED 0 4		was	9 10	and						



State Registrar

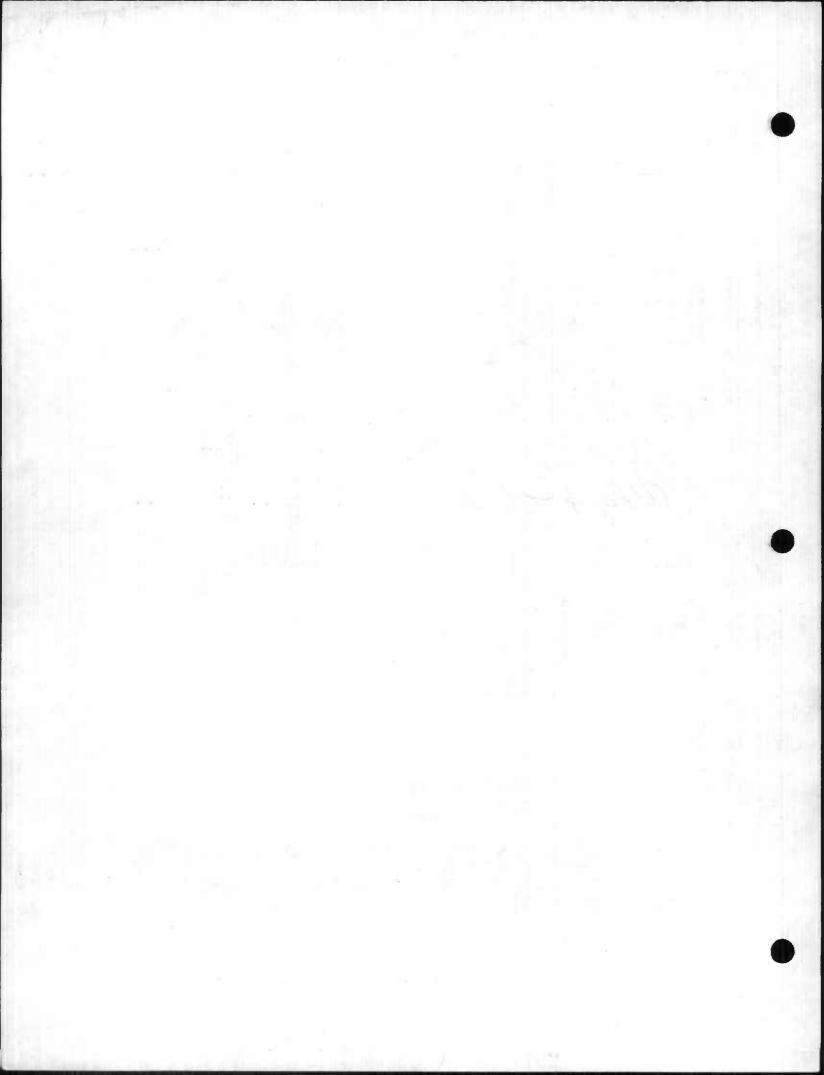
Registrar FEB 0 3 2000

31. Date filed (Month, Day, Year)

32. Registrer's Signeture

gistrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 20a,b,c, per fh G780 2/3/00 ygState of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** December 31, 1999 5:00 PM Hyung Ji · /Medical 4a Fecility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Millenium Nursin Home N.W.
5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) N/A

9. Birthplace (Stata or Foreign Country) Baltimore If Under 1 Year 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Min. 1 ☐ M 2 💢 F Yrs. Director 213-06-0991 88 Jan 10, 1911 N. Korea Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23s or 28s-f show traumatic avent, the Modical Examiner must be nothed at 1 Yes 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21215 4601 Pall Mall Road Korea e filed within 72 hours after death val Hygiene.
other than "natural", or flems 23. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give X
Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: Asian 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 by 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grade complated) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown housewife own home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if frem 27 is marked oth
any Injury or other traumatic avent Be unknown unknown 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 4601 Pall Mall Rd Baltimore, MD 21215 Millenium Nursin Home 20b. Placa of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/2/2000 Baltimore. 21. Signature of Funeral Service RODA 1 0 S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Fink Euneral Home 426 CrainHighway 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events resulting in death) Last and Due to (or as a consequence of): physician the borial Box 68760 Physician/Medical Due to (or as a consequence of): attending 987 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 46 Ûnknown yd bengia Division of Vital Records. λq 8 ilde Meller 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peed completion of cause of death? 58 1 Yes 20'No 1 ☐ Yes 2 ☐ No 918 certifica 25. Was case referred to medical examiner? 88 26. Piace of Death (Check only one) Other: Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1□ Yes SZ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 26d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 28a. Date of Injury (Month, Day Year) 5 Pending 1 [] Yes death. investigation Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital ( within 24 hours a To the Funeral D Coefflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month Day 73ar) 2000

29b. Signature and title of certifier

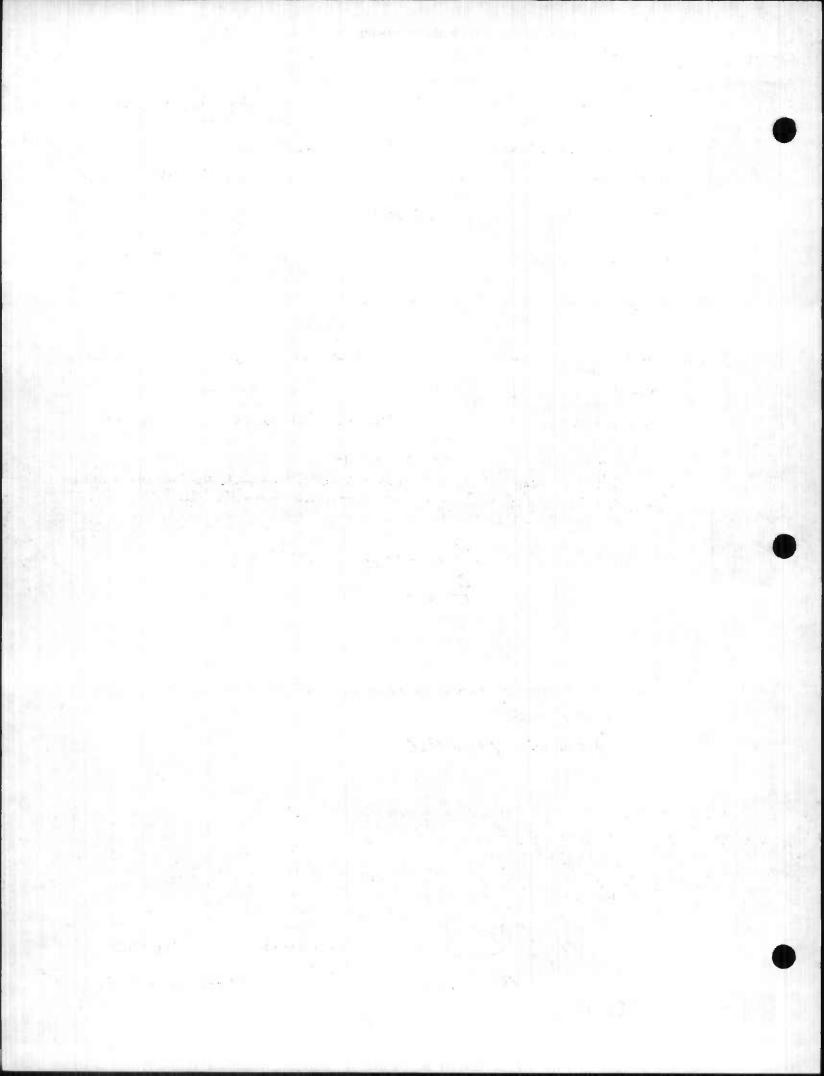
HMAN 32. Pegistrar's Signature enera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

271) Harryands Ray &

**DHMH 16 Rev 6/95** 



Registrar

State

30. Name and address of person was acris

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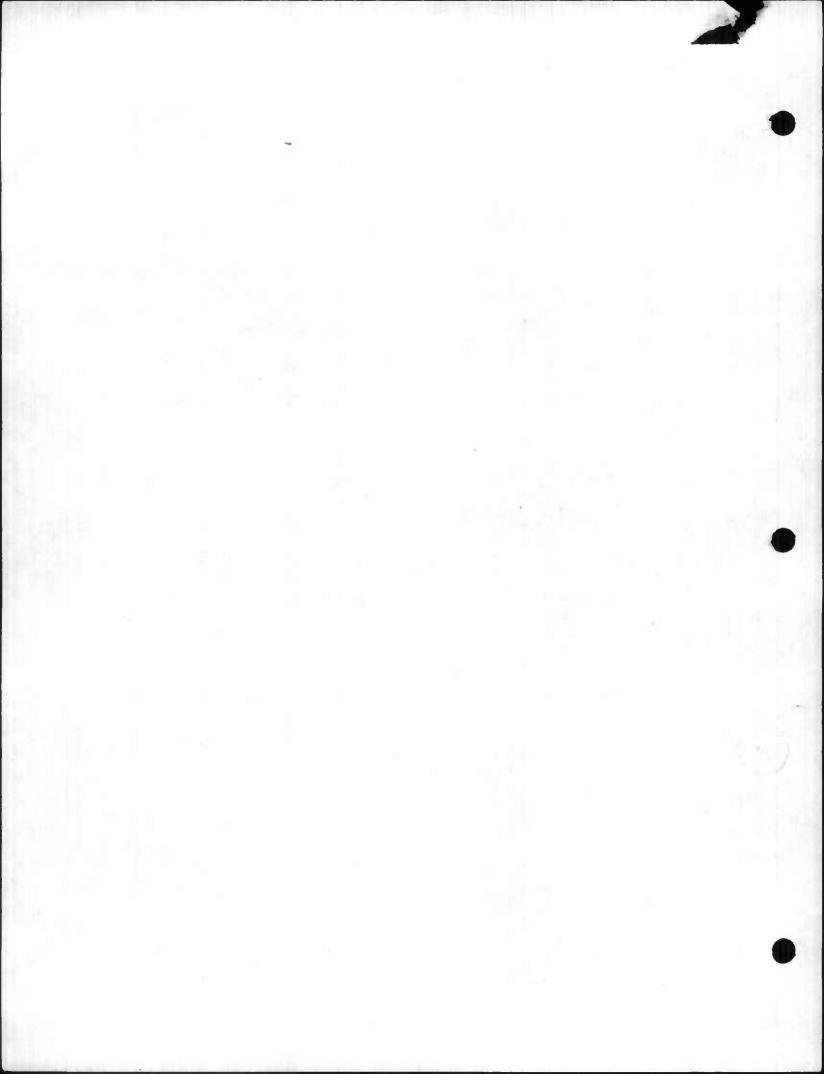
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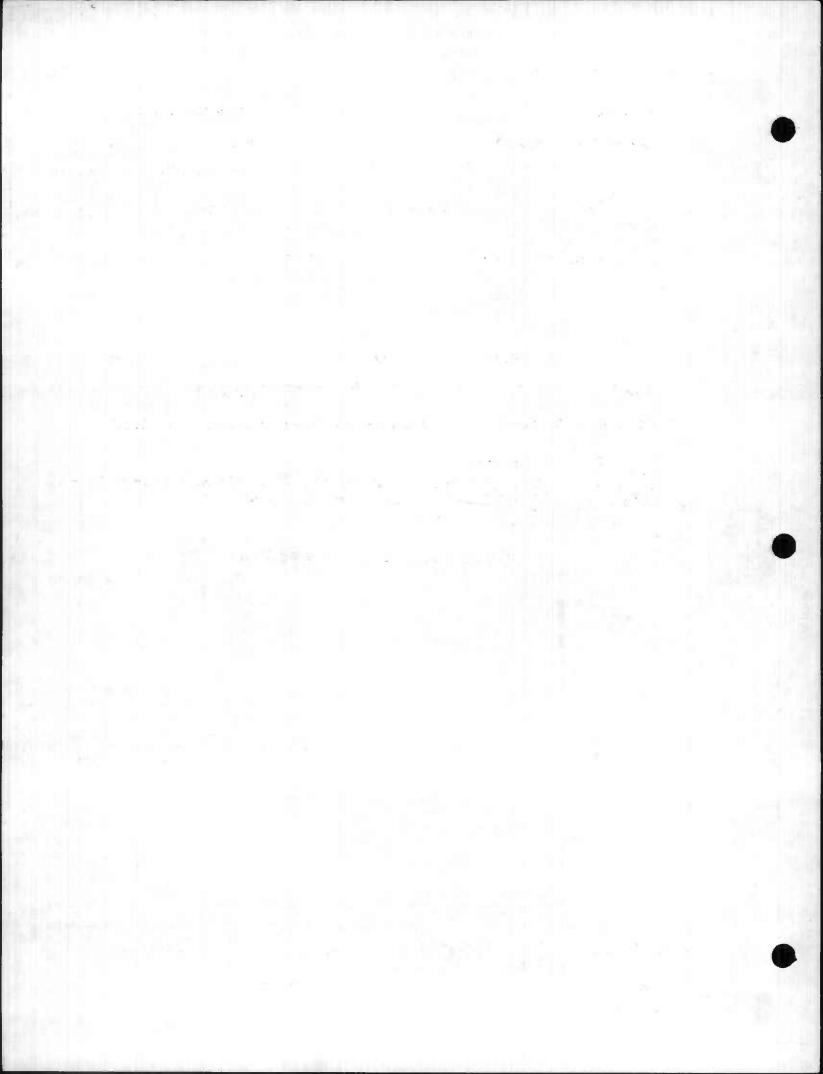
32. Registrar's Signature

POONAI



Amended	Item#24a.26.27 perPh	yG780 2/3/2000 EW	(	Certificate	e of	Death	F	leg. No. 9 9	4	2845		
hysician	1. Decedent's Name (First, Middle, L						2. Date of Dea Month	th Day	Year	3. Tima of Death		
nysician /Medical	Claude Suggs						Decembe		999	12:20 PM		
aminer	4a Facility Name (If not Institution, g	iva street and number)				4b. City, Town, or	Location of Death					
	Johns Hopkins H					Balti	more		N/A			
al or	5. Social Sacurity Number 6.  246-14-7025  Usual Residence of Decedant	Sex 1M M 2□ F 7. Aga (In yrs. 75		Months Months	Days	Hours Min	8. Date of Birth (Month, Day May 26,	1924	Coun	elace (State or Foreigntry) INKNOWN		
blice.  To Be Completed by Funeral Director	10a. Stete 10b. County N/A		ty, Town	or Location					1	0d. Inside City Limits 1 Yas 2 □ No		
Director	10e. Street and Number			10f. Zip	Code			log. Citizen of	What Cour			
Ö				101. 210				og. Oktobrion	Wild Good	, u y ,		
era	2512 E. Monumne	12. Was Decedent Evar in U	IS	13 Was Decede		21205 Hispanic Orlgin? (	Specify Yes or No-		SA a - Amario	ean Indian.		
by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forcas?  1 □ Yes 2 □ No If Yes, Give Yaar or Datas: unkr		If Yas, speci			Specify Yes or No- rto Rican, atc.)	Specify Specify	ck, Whita,	etc. ack		
3	15. Decedent's E	ducation	16a [	Decedent's Usua	Occu	pation	4.5	16b. Kind of B	usiness/Ind	dustry		
Completed	(Specify only highast g Elementary/Secondary (0-12)	rada completed)  College (1-4or 5+)	- 1	life. DO NOT us	e <i>retire</i>	during most of word)	orking					
mo:	9	unknown		unkno	พท			unkı	nown_			
Bec	17. Father's Name (First, Middle, Las					18. Mother's Na	ame (First, Middle,					
0	unknown						unknown					
	19e. Informant's Name/Reletionship	(Type, Print)	19b.	Meiting Address	(Stree		Rural Route Numbe	r, City or Town	State, Zip	Code)		
	Johns Hopkins Ho	ospital	600	N. Wol	fe	Street B	altimore.	MD 2	1213			
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☒ Other (Spec	Removal from State	Placa of	Disposition (Nam r, crematory or of	e of		Data	20c. Location	City or To	own, State		
	4 Donation 5 MOther (Specify) in state  21 Signature of Funeral Sarvice Licensee Pirector State Anatomy Boar							Baltim	ore S	treet		
	23a. Part1. Enter the disease, or con	will.		Baltimo						Approximata		
Examiner	Immediate Cause (Final disease or condition resulting in death)	e. MYOCA(		AL 11 onsequence of):	YF	ARC7	CON		1			
Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or es e co	onsequence of):								
Medical	that initiated events resulting in death) Last		or as a co	onsaquenca of):								
Physician/M	Part II. Other significant conditions	d								23b. Did tobacco use contributa to the causa of death		
						1 □ Yes 2			No 3☐ Probably 4☐ Unknow			
Completed by								performed? available pri		ere autopsy findings allable prior to implement		
mp												
	OF West and a state of the stat						1 Yas 2 No 1 Yes 2 N					
Be	25. Wes case referred to medical examiner?	Hospital:			0	hor:	eath (Check only o					
To	1 ☐ Yes 2 🕅 No 27. Menner of Deeth	1 Inpatient 2 L	ER/Out		A	4 Li Nursing	Home 5 ☐ Resid			(y)		
Certification:	1 🖾 Natural 5 🗆 Pending 2 □ Accident Investigati 3 □ Suicide 6 □ Could not	he	in	Injury Work?  M 1 ☐ Yes 2 ☐ No				cribe how injury occurred				
Certif	4 Homicide determine	28e. Plece of Injury - At h building, etc. (Speci	fy)	m, street, factory	, OTICE		City or Tox		oer or mun	al Route Number,		
edical		hysician: To the best of my knowning.  On the basis of examination and manner stated.										
M	29b. Signature and title of cartifier	1		290	. Licen	sa number		29d. Date signe	ed (Month,	Day, Year)		
	Dawn	) Sell	m	D D	10	2009		1141	00			
	30. Name and address of person who	completed cause of death (item	m 23a) (	Type, Print)		081		1-/-				
	98 N. BROADL	NAY BAI	70	· m	0	7/2	21					
tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	atyte	1	1 ,		01					
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DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** GLADYS TAYLOR 26, 1999 12:01 A.M. December /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chever 1 y Prince George's Prince George's Hospital Center If Under 24 Hrs. 8. Date of Birth October 14, 1928 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□ M 2XXF Deys Months Hours South Carolina 254-40-9609 71 Director Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a Stete 10b. County 1 Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours eiter death with and of Health Hygians. Interfer and Mentel Hygians. Interfer a rarked other than "naturel; or tiems 23a or mrived other than "naturel; or tiems 23a or mry or other traumatic event, its wester fraumer manute." 850 21st Street, N.E. APt. #7 20002 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Stetus Bieck, White, etc. 1 Never Merried 2 Married **Black** 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 8th grade Coilege (1-4or 5+) Yales Laundry (Retired) Laundress 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Magdaline Davis Unknown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 850 21st Street, N.E.Apt. #7 Washington, D.C. 20002 19e. Informent's Name/Reletionship (Type, Print) Mr. Joseph T. Taylor (Husband) 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, State Clinton, Maryland 20e. Method of Disposition 12/30/99 Forest Him is Menor rate Gardens 1XXBuriei 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury of 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. ROTTINS FUNE at 11 Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. a. Fa.f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final CARDIOPYLMONARY diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner CHDDEN DEATH physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): ASYSTOLE tha death certificate be Physician/Medical Due to (or es e consequence of) 88 ASPIRATION. Preumoni A use . signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 □ ⊌nknown 1 ☐ Yes 2 ☐ No HYPERTENSION by 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes an eutopsy performed? DIABETES completion of cause of deeth? page 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificata or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) exeminer r 1 Nes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2D ER/Outpetient 3D DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Neturel 5 Pending after deeth. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide filled in 24 hours 8 Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the cause(s) end manner es stated Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete end pieca, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 12/26/1999 Amil. K. Marajas MD D50689

State

Registrar

FEB 0 3 2000

ANILK MAHAJAN

31. Dete filed (Month, Dey, Year)

32. Registrer's Signature

Aparts

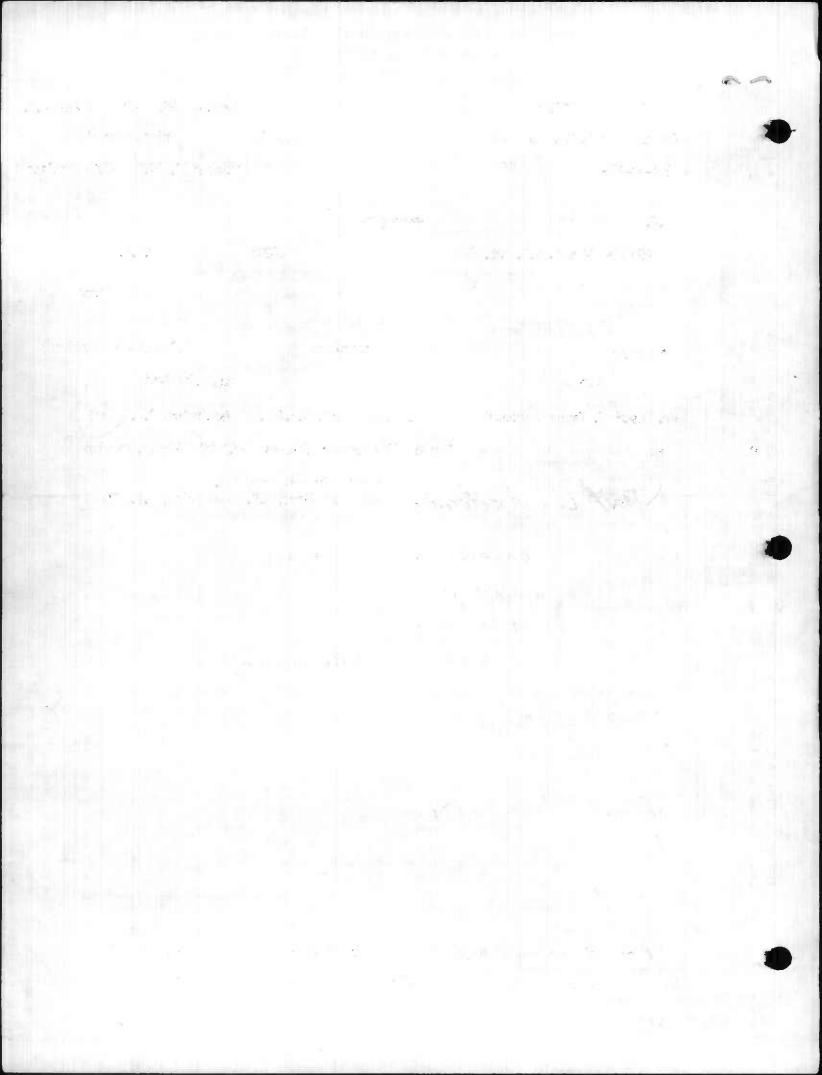
PGHOSPITAL ED. 3001 HOIDITAL DRIVE MD 20985.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DECEMBER 22, 1999

20708

Physician /Medical	
Examine	

**Funeral** Director

with the Marylend show "natural", or items 23s or 28s-4 show Directo Funeral à Completed Be

/Medical

Pages 1 end 2 should be filed within 72 hours after death vent of Health and Mentel Hygiene.
wit: If fear 27 is marked other than "natural; or items 23, my or other traumatic sevent, its Mentel Earning mustry or other traumatic sevent, its Mentel Earning mustry. Baltimore, Maryland 21215-0020 7 is marked other traumatic svent, permit. Pages Depertment of Important: If it any injury or o **Physician** Examiner the death certificate be axecuted physician end the burial-transit Box 68760. Se usa ed by the a thet signed t Records, AR has certificata ha Division of Vital or Attending Physician: this funeral After death. in 24 hou. The Funeral Direction of the Funera To the Hosp within 24 ho To the Fune completely fi

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month JULIA I. BROOKE DECEMBER 21, 1999 7:47 PM 4a Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth PRINCE GEORGE'S LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Yrs. MAY 26, 1929 WASHINGTON DC 70 579-34-3365 Usuei Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MARYLAND CHARLES WALDORF 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20602 UNITED STATES 729 UNIVERSITY DRIVE 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No if Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JOHN F. REARDON, SR. CATHERINE E. LANGLEY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29721 BRICH CIRCLE, FRANK E. BROOKE, SR. - SON MECHANICSVILLE, MD 20659 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State RESURRECTION CEMETERY 12/29/99 CLINTON, MARYLAND 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licente 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC. Thanh 20 Drotas P.O. BOX 156, WALDORF, MARYLAND MARK G. BROHAWN M00053 20604 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Betw Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) RESPIRATORY FAILURE Due to (or es e consequence of): Examiner METASTATIC CARCINOMA LUNG Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): CHRONIC OBSTRUCTIVE DISEASE Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA OVARY þ 24b. Were autopsy findings avellable prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Yes 2 No 1₺ Inpatient 2☐ ER/Outpatient 3☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and little of ceptifie 29c. License number 29d. Date signed (Month, Day, Year)

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LAUREL, MARYLAND

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

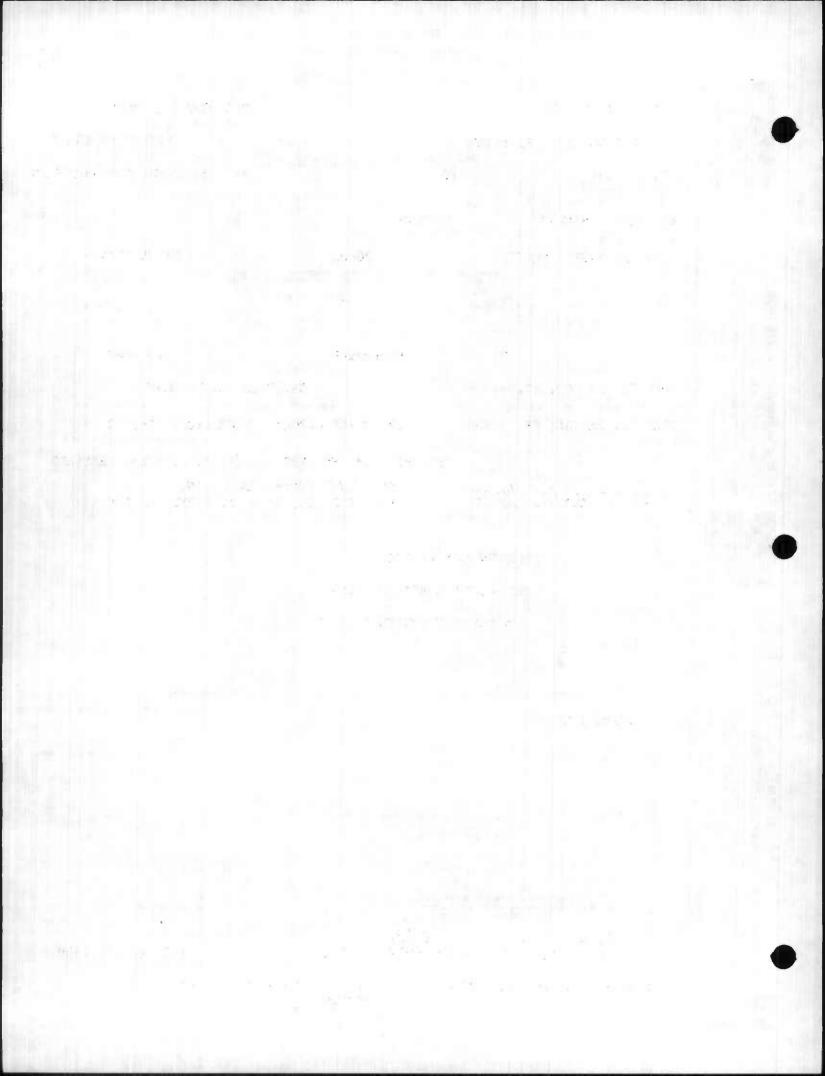
NEIL A. MEADE, MD 31. Dete filed (Month, Day, Year)

9811 MALLARD DRIVE

32. Registrar's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Clinton LeRoy Bonser 27 1999 12:05 PM December /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SALISBURY ATRIA SALISBURY WICOMICO If Under 24 Hrs. 6. Sex 1 → M 2 □ F If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs Director NOV. 23, 1918 PENNSYLVANIA 207-05-6221 81 Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location tOd. Inside City Limits r than "natural", or home 23a or 28a-f show the Madical Examiner must be notified at 1 Yas 2 No Directo DELAWARE SUSSEX MILLVILLE 10e. Street and Number 10f. Zio Code 10a. Citizen of What Country? 129 MAIN STREET 19970 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. Wher then "neturel", or its 1 X Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE p 3 X Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygland Important: If Item 27 is marked other the early injury or other traumatic event, the page. STEEL PRODUCTION 12 FOREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EMMA** F. OTTIWELL J. BONSER SLIKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA L. O'BOYLE/DAUGHTER P.O. BOX 1007, OCEAN VIEW, DELAWARE 19970 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETHLEHEM MEM. PARK CEM. 1/8/00 BETHLEHEM, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Pert1. Enter the disease, or complications that sheet the shock, or heart failure. List only one cause on the line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to for as a consequence Examiner physician and s the burial-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): aftending p signed by the air Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown Records, by should t 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home \$ Desidence 6 Other (Specify) 1 Yes No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 DiNatural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1208 Occum Highway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + IVA Nicholas Flurkt + oler ochella

**DHMH 16 Rev 6/95** 

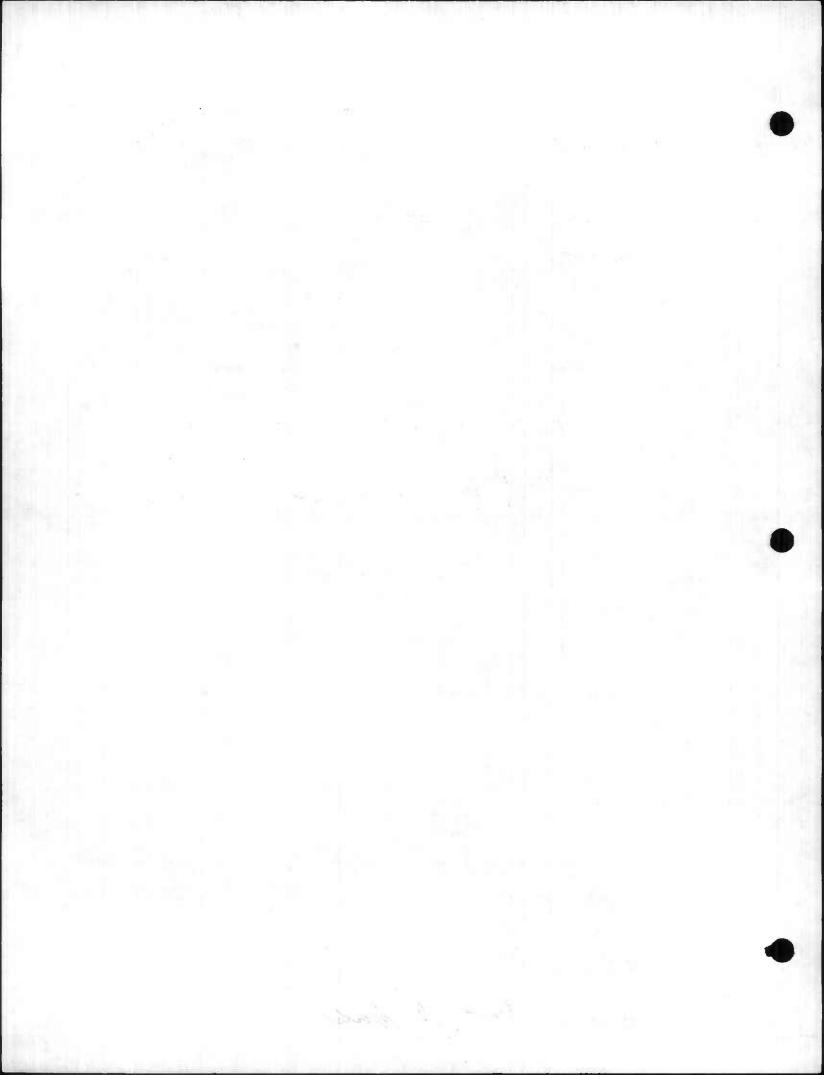
State

Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

Registrar's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Colyns 9:40 PM CAMOHIT (ELBA) 12 23 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 309 STREET CLEALLING O WICO MILL MORRIS Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 100 20 F 216-38-9124 58 MALGLANd Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits RuHANd 1 Nos 2 No LOMILO La 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 MERKIS STERRI 21826 454 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced LEO AMALICIAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 Ruck Country URIVER. SOMELS EST 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Edward CILLINS M. E, Almudosa 19e/Informent's Neme/Relationship (Type, 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 4016 ROOK 365 MALYLANDO SKKKON Mollis CAHHNA 20b. Plece of Disposition (Name of cemetery, crematory or other p 20e. Method of Dieposition Date 20c. Logition - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) & MB TEL 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility BNN md. 5 w Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Cause (Final MINVIO MYOCARDIAL INCARCTION disease or condition resulting in deeth) Due to (or as a consequence of): 1-2 mos. ART. DISCOSE Due to (or as a consequence of) Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? FAILURE

**Physician** /Medical Examiner

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signed t

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Certification: To

Medical

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleky filled in by the funeral director.

To the Within 2

the death certificate be executed

Box 68760.

P.O.

Records.

Division of Vital

**Physician** 

/Medical

Examiner

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Completed

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**Funeral** 

Director

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Hygiene.

Important: If them 27 is marked other any injury or other teams.

72 hours after

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Pages 1 and 2 should

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical þ Completed

3 ☐ Suicide

4 Homicide

31. Dete filed (Month, Day, Year)

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REMAL MULTEICIONO 1□ Yes 2 No 25. Wes case referred to medical exeminer?

1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 2 Accident

6 Could not be determined 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signeture and title of certifier 29c. License number

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29d. Date signed (Month, Day, Year) 12-30 99

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1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

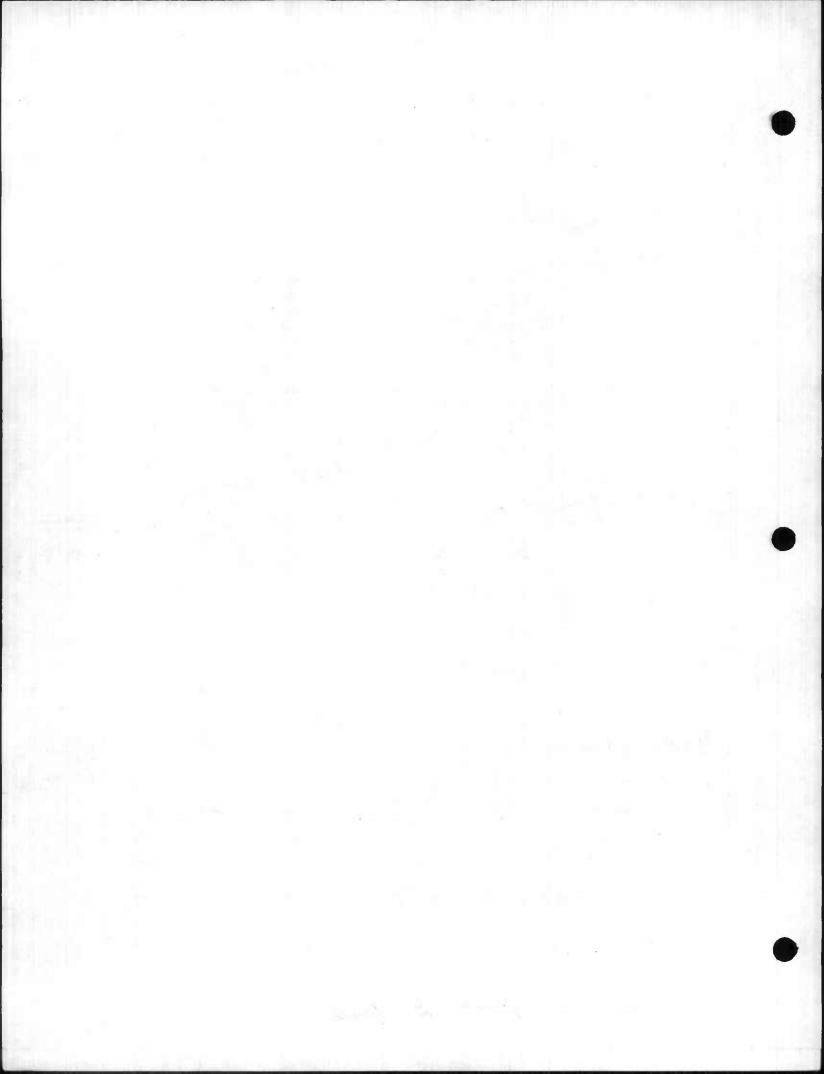
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37. Registrer's Signeture

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Registrar



P.O. Box 68760, Records, Division of Vital

the Maryland

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filed within 72 hours after of Hygiene.

Baltimore, Maryland 21215-0020

Show

**Physician** /Medical **Examiner** physician and s the burief-transit The law requires that the death certificate be executed ettending | for use as signed by the e peen page 2 certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and gnanner steted. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) 105 Pine Policy Rose

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32. Registar's Signatura

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State Registrar

32. Registrar's Signatura

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth Month Day Day 1999 2:55 PM REEDA HACKMANN 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Baltimore If Under 24 Hrs. 8. 715 Maiden Choice Lane Baltimore If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Min. 1□ M 2X F Months Deys Hours Yrs. Apr 20, 1909 212-40-3255 Usual Rasidance of Decedant MD 90 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Baltimore Baltimore 10e. Streef and Number 10f. Zip Coda 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA Race - American Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Nama (First, Middle, Maiden Sumame) 12 teacher 17. Father's Name (First, Middle, Last) David M. Stafford Sarah E. Maglidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Dadin/daughter 104 Great Oak Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 X Donation \_5 ☐ Other (Specify) 21. Signature of Furneshi Service Licensee Ronal Ld S Wade. 3 Partend Addresoff Board 655 W. Baltimore Street Director nun 21201 Baltimore, MD 23a J intl. Enter the disease/ or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, nock, or haari failure. List only one cause on each lina. Approximete Interval Between Onset and Death Colon Immediate Causa (Final diseese or condition resulting in death) Aleuoriar inoma Dua to (or as a consequance of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilabla prior fo 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 25 No 1 ☐ Yes 2 2 40 25. Was case referred to medical axaminar? 1 ☐ Yes 2 No 26. Place of Death (Check only ona) Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Nafural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide

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Examiner Physician/Medical þ Completed Be Certification: To

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/Medical

Examiner

**Funeral** 

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Department of Health as important if from 27 is any injury or other trait once.

**Physician** 

/Medical

Examiner

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Baltimore, Maryland 21215-0020

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Funeral

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29a. Certifier (Check only one) 29b. Signature and title of certifian

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Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rello

29c. License number

D51018

29d. Date signed (Month, Day, Year)

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

L. Pinto, Douglas MD JAN 2 1 2000

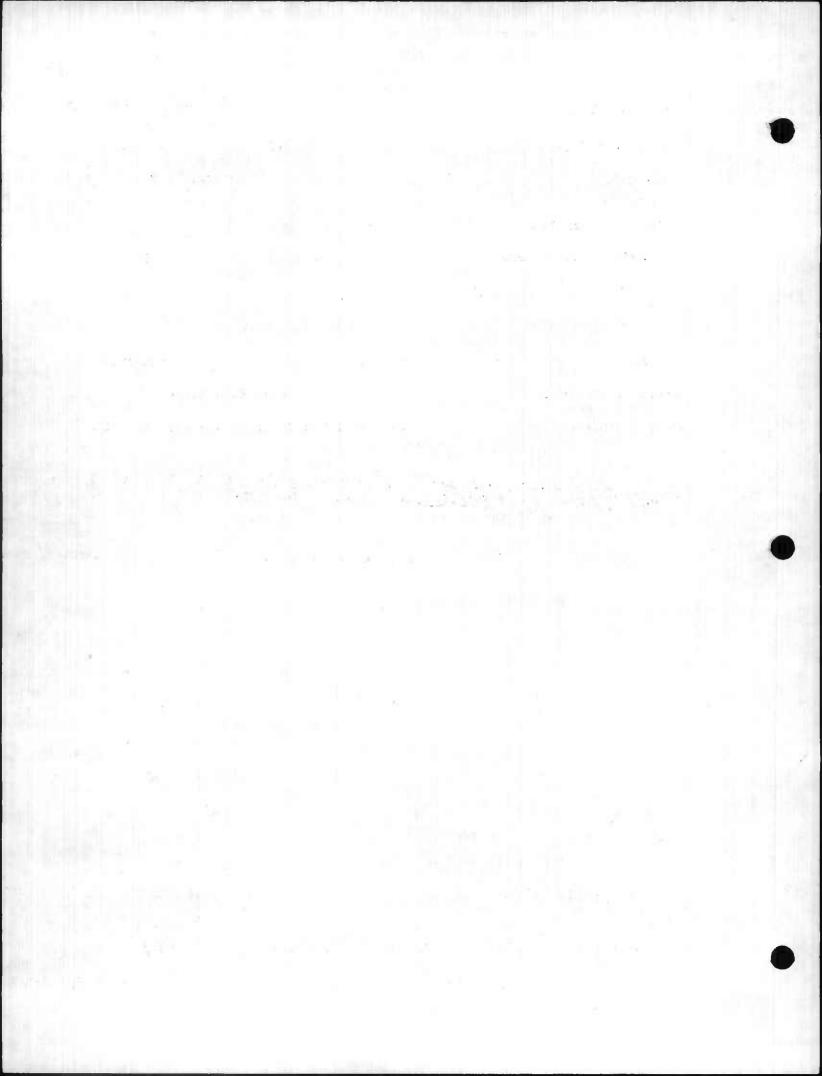
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3421 32. Registrar's Signatura

28e. Piace of Injury - At home, farm, street, factory, office building, atc. (Specify)

Benson Ave., Suite 230 Baltimore, MD 21227 oaks

State Registrar



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year Physician 12 9:20 PM Patsy Hull 29 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9025 Star Road Delmar Wicomico If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10M 20F 54 213-44-2284 Director 9/6/1945 Maryland **Usual Residence of Decedent** the Maryland 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flama 23s or 28s-f show 1 ☐ Yas 2 ☐ No Directo Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9025 Star Road 21875 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hyglens. Important; if Item 27 is marked other than "natural", or than any injury or other traumatic event, the Medical Examines. 9058. Black, White, etc. 1 Yes 2 \No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Truitt Kathryn T. Bradford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald M. Hull Sr. / Husband 9025 Star Road Delmar, Maryland 21875

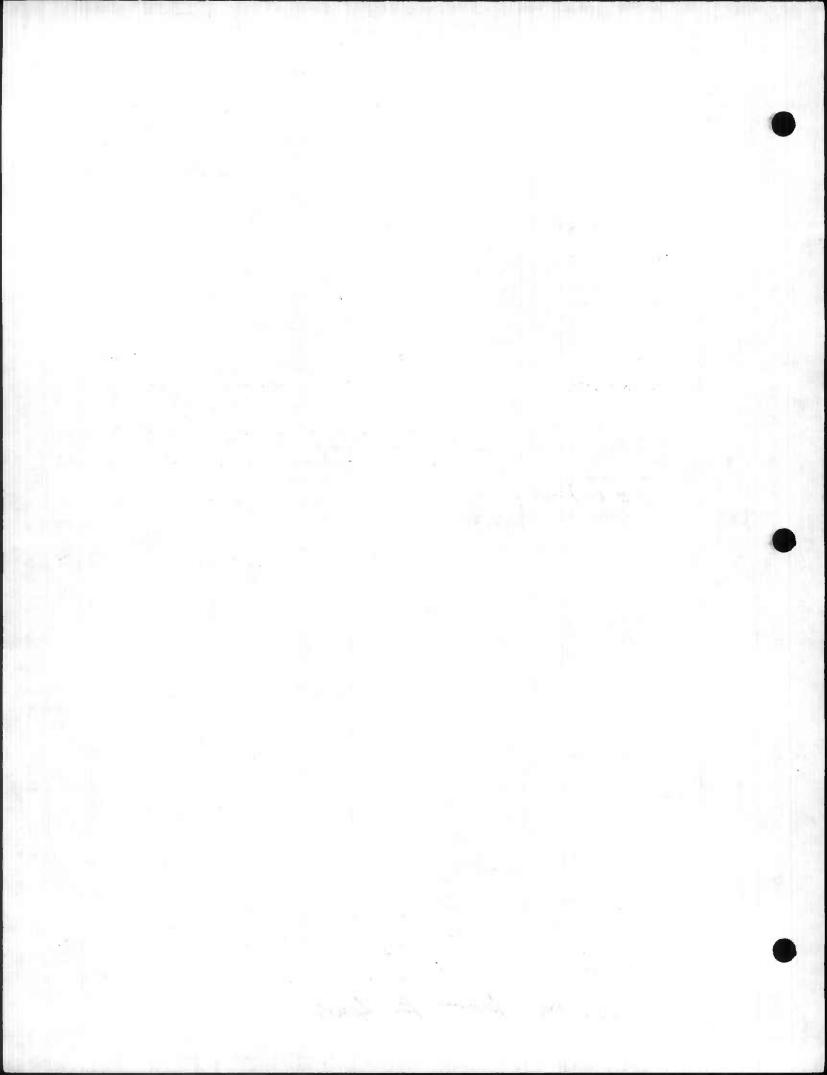
Oa. Method of Disposition 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Springhill Memory Gardens 4 Donation 5 Dother (Specify) 1/5/00 Hebron, Maryland 21. Signature of Funeral Service Licensee 22, Name and Address of Fscility Keith R. Kourey Holloway Funeral Home, Salisbury, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a d be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were sutopsy findings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? has 2/2 No certificata 1 Yes 1 Tyes Division of Vital e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifical lately filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 200 2 5 Aesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Die 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Natural 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune complately fi (Check only one) 29d. Date signed (Month, Day, Year) 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57. Salish MO als 61 8 :oun1 M) 175 32. Regultrer's Standure 145E Carroll

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

JAN 04 2000



Amended #19a, NLS, 1/24/00, Allegany Co.

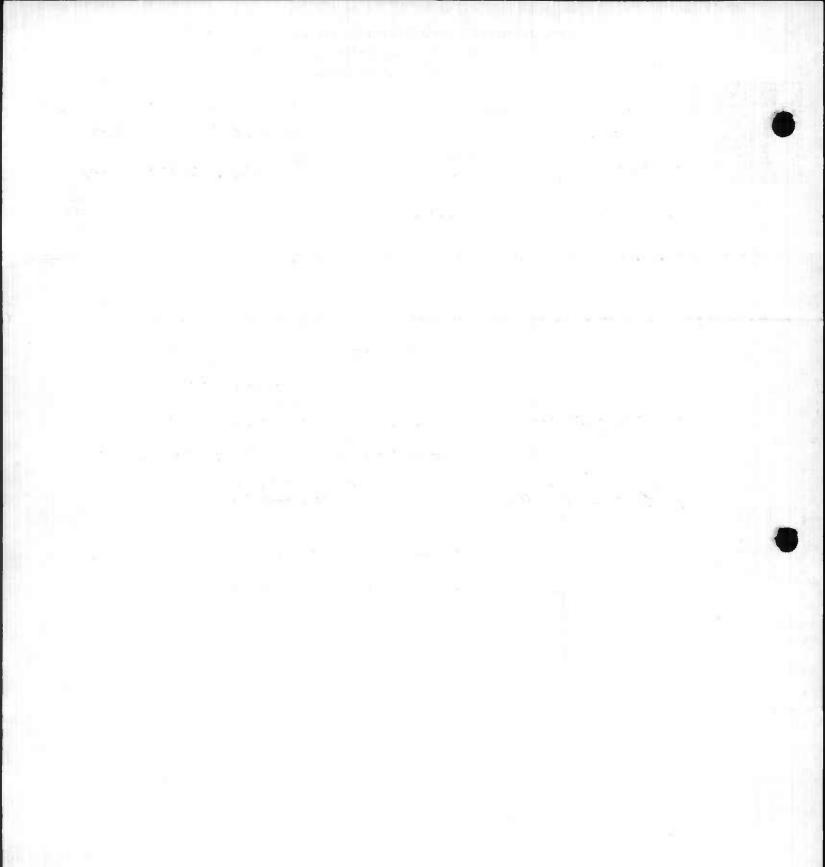
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death 3. Tima of Death **Physician** Month Shirley 6:31PM Dec 1999 A Myers 21 /Medical 4a. Facility Nama (If not institution, giva street and number)
Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death
Allegany **Examiner** Cumberland 7. Aga (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours 219-56-8165 Yrs. 54 Director Dec. 20, 1945 Maryland Usual Rasidanca of Deceden with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. insida City Limits r than "natural", or Itams 23a or 28a-f shore The Medical Examiner must be notified at WV 1 Yas 2 □ No Directo Morgan Paw Paw 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? P. O. Box 202 death Funerai 25434 USA 12. Was Dacadant Evar in U,S Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or han any injury or other traumetic event, the Medical Eventua Armed Forcas?
1 ☐ Yas 2 ☒ No
If Yas, Giva Black, Whita, atc. 1 Navar Marriad 2 TX Married Maryland 21215-0020 1 ☐ Yas 2X No Specify: à 3 Widowad 4 Divorced White 16e. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Household 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnema) Be Edward Seed Ryan Georgia Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) Michael Myers/husbad husband P. O. Box 202 Paw Paw, WV 25434 altimore. 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramovai from Stata Camp Hill Cemetery 12/24/99 Paw Paw, WV 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Fraley-Kimble Funeral Home 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Paw Paw, West Virginia Approximata intarval Batween Onsat and Death **Physician** /Medical immadiata Ceuse (Finel disaesa or condition rasulting in daath) Ventricular fibrillation 15hrs Examiner Dua to (or as a consequenca of) Examiner ük Arteriosclerotic heart disease certificeta be axacuted the burial-transit Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Ceusa (Disease or Injury that initieled avants rasulting in death) Last and Dua to (or as a consequence of): physician P.O. Box 68760 Physician/Medical Dua to (or es a consequança of) USB BS attending | ed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy Completed hes page 2 certificata 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: director Be 25. Was casa raferred to medical 26. Placa of Deeth (Check only ona) axaminar? Hospitel: Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) 2 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 28e. Dete of Injury / (Month, Dey Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Netural 2 Accident 5 Panding invastigation o the Hospital or Attending ithin 24 hours aftar daeth. o the Funeral Director: Afte 1 Yes 2 No 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29a. Certifian To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signature and title of certific 29c. Licansa number 29d. Data signed (Month, Day, Year) Dec 21 1999 Dpty Med Ex D 09157 5 pencer who completed causa of death (Itam 23a) (Type, Print) nus Snow, 124 W 3rd ST Cumberland Md 21502 Paul M.D. JAN 2 4 2000 32. Ragistrar's Signature

State Registrar

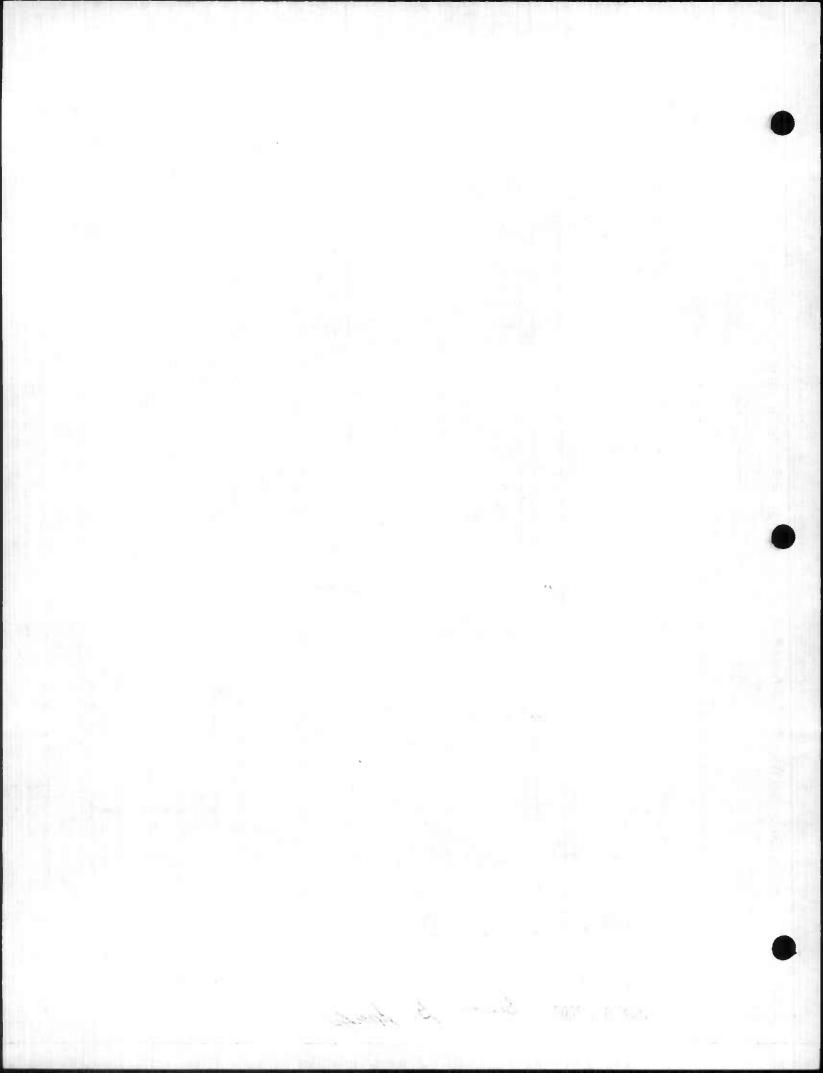
**DHMH 16 Rev 6/95** 



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State of Maryland / Department of Health and Mental Hygiene 99 42855

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Director	10	De. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	ountry?	
		1016 E. Schumake	er Manor	Dr			21	804			US	A		
by Funeral	11	Marital Status     Never Married 2 Married     Widowed 4 🔯 Divorced	12. Was Deced Armed Ford 1 K Yes 2 If Yes, Give Year or Dat	Army		Was Deceded If Yes, special Yes 2			gin? (Sp , Puerto	ecify Yes or N Rican, etc.)		Race - Ame Black, Whit ecity:		in,
	H	15. Decedent's I	Education		16a. Dece	dent's Usua	l Occup	ation			16b. Kind	of Business	/Industry	
Completed	-	(Specify only highest g Elementery/Secondary (0-12) 12	College (1-	for 5+)	tife.	kind of work DO NOT use ant Ma	e retired	3)	OF WORK	ing	Per	osi Co	ala Co	
	17	. Father's Name (First, Middle, Las	st)		LTC	iiic na	nage		r's Name	e (First, Middl	le, Maiden Sui		ia cc	
o Be		Ralph Hillary	Metz					Ka	atie	Turney	Y			
	1	9a. Informant's Name/Relationship	(Type, Print)								ber, City or To			
		Larry A. Whitt/	Life Part	ner	101	16 E.	Sch	umaker	c Mai	nor Dr.	., Sali	sbury	, MD	
	20	De. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	Removal from Si	lata	Place of Dispondencementary, creating the control of the control o	metory or ot	ther plac	>e)		Date 1/4/00		ion - City or sbury		te
8300	2	1. Signature of Funeral Service Lice  Keith R. Wow			2	2. Name and HOLLO	way	Fune	ral	Home Pr	rofessi	ional	Asso	ciation
	2	3a. Part1. Enter the disease, or conshock, or heart failure. List only		used the dea ch line.	th. Do not en				Rd.	, Salis	sbury,	MD 21	Approx	Between
	In			ng	th. Do not en	ter the mode	of dyin	ng, such as	Rd.	, Salis or respiratory			Approx Interva Onset	l Between and Death
	In	3a. Part1. Enter the disease, or conshock, or heart failure. List only nmediate Cause (Final sease or condition		ng	Ca	ter the mode	of dyin	ng, such as	Rd.	, Salis or respiratory	arrest,		Approx Interva Onset	l Between and Death
Examiner	In di	3a. Part1. Enter the disease, or co- shock, or heart failure. List onl mmediate Cause (Final isease or condition sulting in death)		10 ( 10 ( 10 (	Ca	quence of):	of dyin	ng, such as	Rd.	, Salis or respiratory	arrest,		Approx Interva Onset	l Between and Death
edical	In dire	3a. Part1. Enter the disease, or conshock, or heart failure. List only nmediate Cause (Final sease or condition	mplications that ca y one cause on ea a	Due to (	Ca or as a conse	quence of):	of dyin	ng, such as	Rd.	, Salis or respiratory	arrest,		Approx Interva Onset	l Between and Death
edical Examiner	Indidice Silico C the re	3a. Part1. Enter the disease, or co- shock, or heart failure. List onl mediate Cause (Final isease or condition isulting in death)  equentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or injury at initiated events	mplications that ca y one cause on ea a	Due to (c	or as a conse	quence of):	e of dyin	ng, such as	Rd. cardiac	, Salis	arrest.	tion	Approximately on set	l Between and Death
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by Physician/Medical Examiner	Indidice Silico C the re	3a. Part1. Enter the disease, or co- shock, or heart failure. List only mediate Cause (Final sease or condition suiting in death)  equentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or injury at initiated events southing in death) Last	mplications that ca y one cause on ea a	Due to (c	or as a conse	quence of):	e of dyin	ng, such as	Rd. cardiac	, Salis or respiratory & E fun 23b. Did 15	d tobacco use	tooi	Approximately Ap	use of death?  4 Unknown
by Physician/Medical Examiner	Indidice Silico C the re	3a. Part1. Enter the disease, or co- shock, or heart failure. List only mediate Cause (Final sease or condition suiting in death)  equentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or injury at initiated events southing in death) Last	mplications that ca y one cause on ea a	Due to (c	or as a conse	quence of):	e of dyin	ng, such as	Rd. cardiac	, Salis or respiratory & E tu 23b. Did 15	d tobacco use	tori	Approximately Approximately III    to the carrobably    Were auto available prompletic completion	use of death?  4 Unknown  ppy findings  no of cause
Physician/Medical Examiner	Indidice Sife CC that re	3a. Part1. Enter the disease, or co- shock, or heart failure. List only mediate Cause (Final sease or condition suiting in death)  equentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or injury at initiated events southing in death) Last	mplications that cally one cause on each a b b c d contributing to dea	Due to (c	or as a conse	quence of):	e of dyin	ng, such as	Rd. cardiac	, Salis or respiratory & E tu 23b. Did 15	d tobacco use 2 1 1 san autopsy formed?	tori	Approvinterva Onset	use of death?  4 Unknown  use of death?  4 Unknown  psy findings  nof cause
To Be Completed by Physician/Medical Examiner	Indicate Sife CC the record of	3a. Part1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final isease or condition is utility in death)  equentially list conditions, any, leeding to immediate tause. Enter Underlying ause (Disease or Injury at Initiated events is utility in death) Last  art II. Other algnificant conditional in II. Other algnificant conditional examiner?	mplications that cally one cause on early one cause	Due to (c	or as a consector as	quence of):  quence of):  quence of):  quence of):	e of dyin	ren in Part I.  26. Place	Rd. cardiac of Deet	23b. Did  24a. We per  th (Check only)	d tobacco use  d tobacco use  as an autopsy formed?  Yes 2  yone)  sidence 6	tool contribute No 3 P 24b.	Approvinterva Onset	use of death?  4 Unknown  ppy findings  no of cause
o Be Completed by Physician/Medical	Indicate Sife CC the record of	3a. Part1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final isease or condition is utiling in death)  equentially list conditions, any, leeding to immediate tause. Enter Underlying ause (Disease or Injury at Initiated events is utiling in death) Last  art II. Other algnificant conditional is used.	mplications that cally one cause on early one cause one cause on early	Due to (c	or as a consector as	quence of):  quence of):  quence of):  quence of):	ause giv	ren in Part I.  26. Place	Rd - cardiac of Cardiac of Deet	23b. Did  24a. We per  th (Check only)	d tobacco use  d tobacco use  an autopsy formed?  Yes 2	tool contribute No 3 P 24b.	Approvinterva Onset	use of death?  4 Unknown  use of death?  4 Unknown  psy findings  nof cause

30+1VA

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 04 2000

29b. Signature and title of qu

32/Registrar's Signature

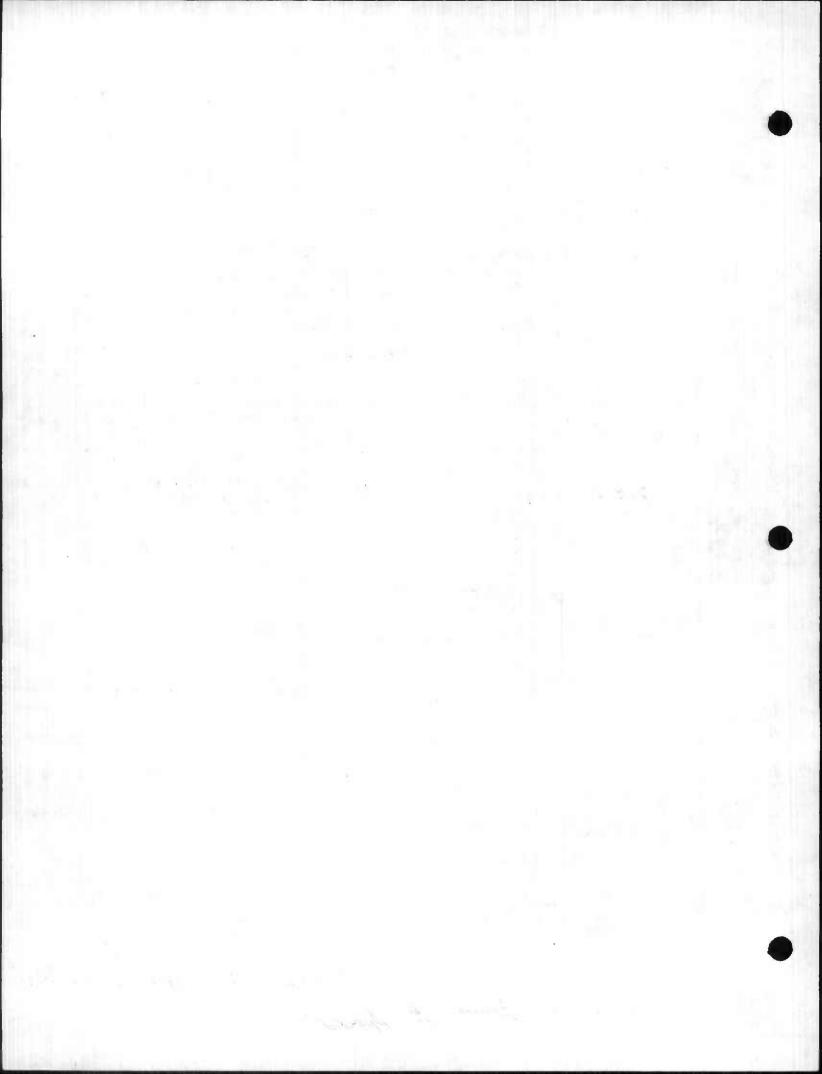
D-052520 1 03/00
Tilghman Rd, Salisbury MD

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95

29c. License number



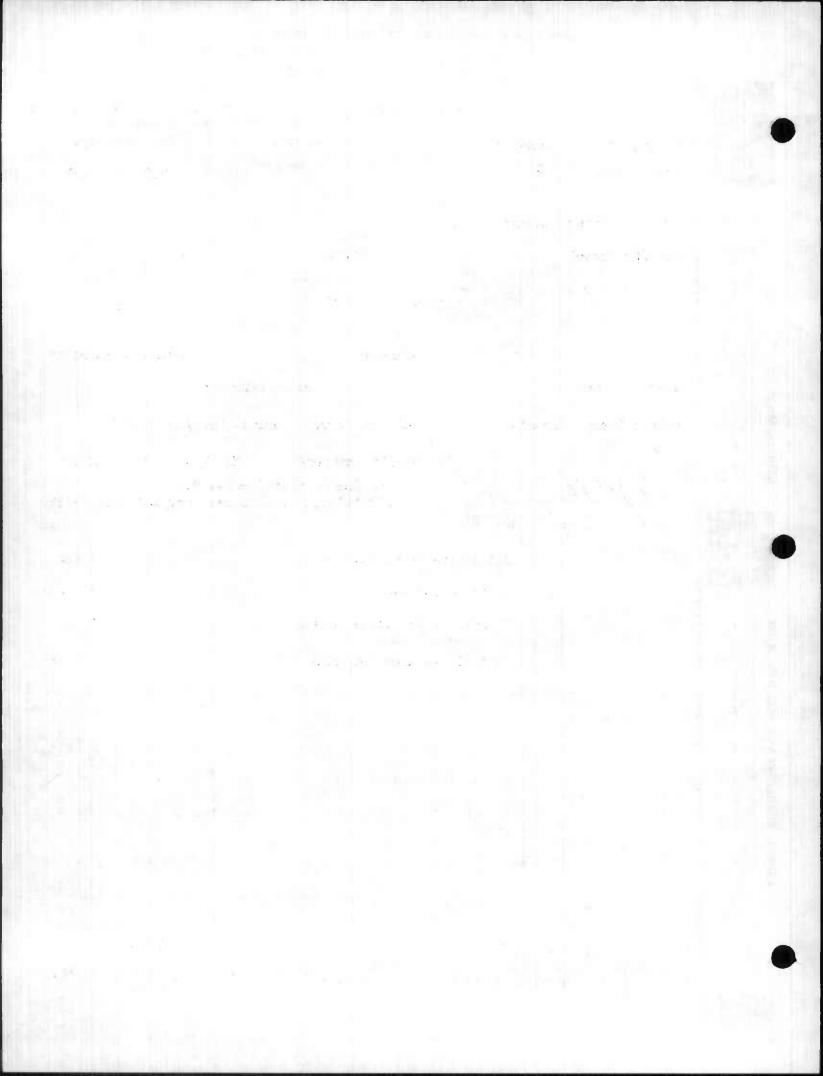
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Deta of Deeth 3. Time of Deeth Month Dey Yeer December 31, 1999 **Physician** 2:25 pm John Donnelly Brady /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Prince George Laurel Regional Hospital If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yaer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthpleca (Stete or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Min. Yrs. 126-01-3974 81 Oct 05, 1918 | New York **Director** Usuel Residence of Decedent with the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director MD Prince George Laurel 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code is 1 and 2 should be filed within 72 hours after death with in Health and Mental Hygiena.
Item 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examines must be a 407 5th Street 20707 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (X/Yes 2 □ No If Yas, Give Yaer or Detes: 1942–45 Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Biack, Whita, atc. 1 Never Married 2 Married Specify: White Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Building Industry Salesman 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) John J. Brady Alice Donnelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Esther Brady /spouse 407 5th Street, Laurel, Maryland 20707 altimore, important: if Nem any Injury or other once. 20b. Pieca of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Pages 1 ☑ Buriel 2 ☐ Cremelion 3 ☐ Removal from State 4 ☐ Donelion 5 ☐ Other (Specify) St. Mary's Cemetery 1/6/00 Laurel, Maryland permit. P 21. Signature of Bungray Se 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, may one cause on each line. 23a. Pert1. Enter the dis-shock, or heart failure Approximete Interval Between Onsal and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Congestive Heart Failure l year Examiner Due to (or es e consequenca of) Examiner Severe emphysema 15 years physician and the bunal-transit tha death cartificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Chronic Atrial Fibrillation 3 years Physician/Medical Due to (or es e consequenca of): usa as t Multiple infarct dementia 2 years Pol ed by the a 23b. Did tobacco use contribute to the cause of death? Pert tt. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert !. 1 No 2 No 3 Probably 4 Unknown signed t urosepsis ð 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes an eutopsy performed? completion of cause of deeth? has paga 2 1 Yes 2 No 1 Yes 28 No certificata Physician: director Be 25. Wes case referred to medical axaminer? 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA this funaral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Aftar Attending 1 X Neturel 5 Pending or Attending after death. Director: Aft 1 Tyes 2 No investigation 2 Accident the 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 6 4 Homicide filled in 24 hours 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dele end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner stated. 29e. Certifie edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier D136 1/03/00 anay jet Laurel park or Laurel mo 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 20707. MANEJWALA 14201

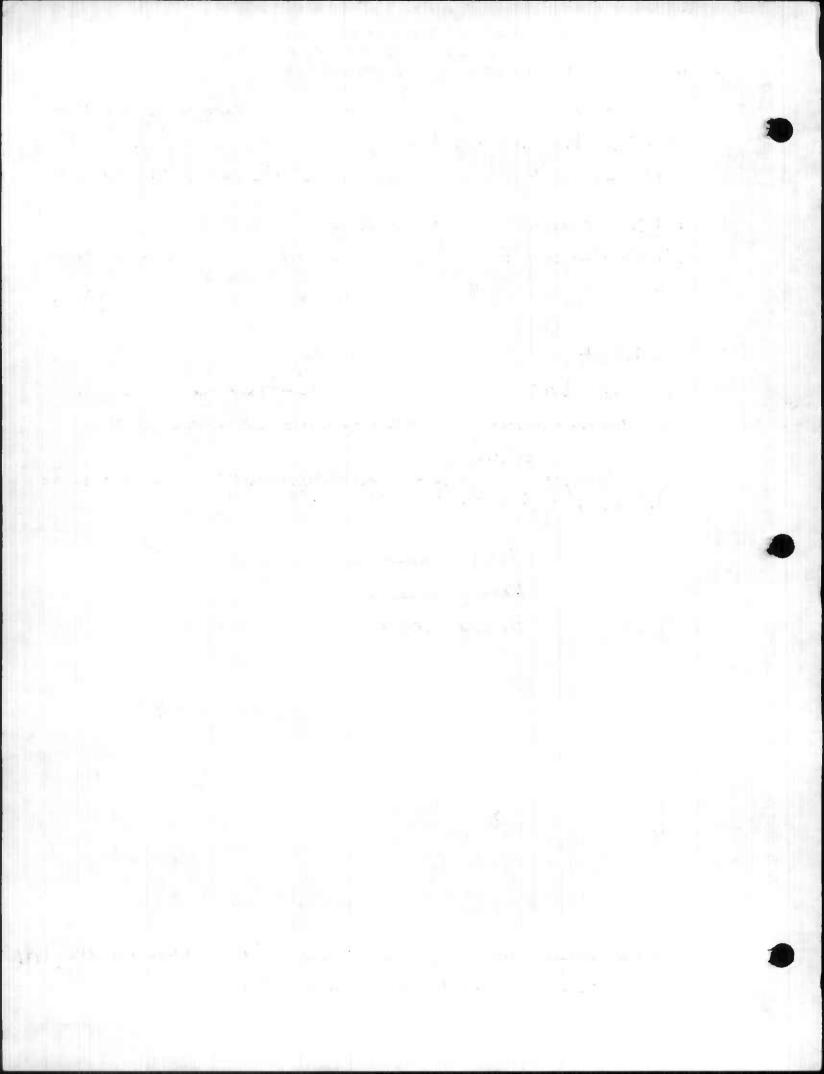
State Registrar

32. Rygistrar's Signeture



Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** James Edward Holt December 30, 1999 3:40 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs. 403-36-0821 69 Director Mar 06, 1930 Oklahoma Usual Residence of Decedent the Maryland 10a. Stete 10b. Counts 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or frame 23a or 28a-f show traumatic svent, the Medical Examples invariate monthled at 1 ☐ Yes 2 ☐ No MD Howard Director Highland 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 7173 Mink Hollow Road 20777 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. should be filed within 72 hours efter 1 XYes 2 No if Yes, Give Year or Dates 1948-52 1 Never Merried 2 Merried altimore, Maryland 21215-0020 Specify White 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States al Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) Government Engineer 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Is marked of Ray Leslie Holt Margaret McGee 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Health and Important: If Nem 27 Is in any Injury or other traum page. Lenore Holt /spouse 7173 Mink Hollow Road, Highland, Maryland 20777 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriei 2 □ Cremetion 3 □ Removei from State 4 □ Donetion 5 □ Other (Specify) Maryland Veterans Cem 1/4/00 Crownsville, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the distance of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart taking the cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner IRator ZWKS certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest buriel-tran Due to (or es e consequenca of) pue 2wks physiclan Physician/Medical Due to for es e consequence of): the SE 980 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. the signed by t 2 No 3 Probably 4 Unknown 1 Yes by 24b. Were eutopsy findings available prior to Completed Heart Failure 24e. Wes en eutopsy performed? completion of cause of death? certificate has 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Deeth

1 Neturel
2 Accident 28e. Date of Injury (Month, Day Year) Inneral 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? Certification: or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after deeth Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours The criffying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as leted. Medical 29a. Certifier (Check only one) To the P within 2 To the F 29b. Signatura a 29c. License number 29d. Date signed (Month, Day, Year)

vet State

Registrar 2000

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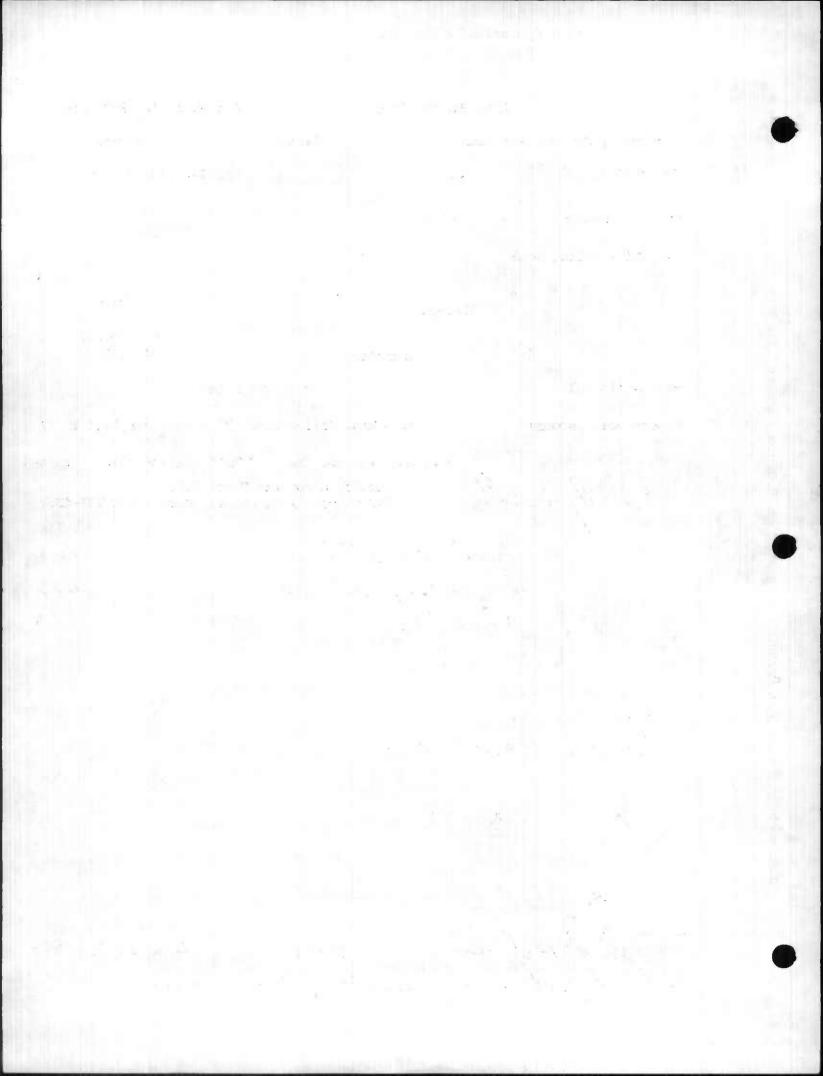
32. Registrer's Signeture

MD

eted cause of deeth (Item 23e) (Type, Print)

D5/90

Drive Sule 327 Olne, Marylon



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#11,23a perPhyG780 2/9/2000 EW 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 12 7:30 /m ANERIO 28 Fedity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Hevery If Under 24 Hrs. 8. Date of Birth Month, Dey, Pital Center KiNCE GEORGES GEORGE If Under 1 Year Months Deys 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10M 20 F Hours Deys Yrs. DEC. None Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No KINEE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20749 2700 vuri 1. 5. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Stetus Bleck, White, etc. 1. Never Married Amerried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1□ Yes 2⊡No SIACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LNFANI IN/MINI 49W1 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Mucphy Acteen hoate MURPHY WARREN 19e Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) herechy no 21785 KiNEE PHIC 5001 enter 20e. Method of Disposition 20b. Piece of Disposition (Name of competery, crematory or other place) Dete 20c, Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel fr 4 Donetion 5 Que 150 April 1

22. Neme end Address of Facility

**Physician** /Medical

Examiner

the attending physician and hed for use as the burial-transit

signed by

this funeral

After Attending

3

completely

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al

page 2 should

Be

2

Certification:

edical

Box 68760. certificate be

P.O.

Records,

Division of Vital

**Physician** 

/Medical

Examiner

10e. Stete

Directo

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or flama 23s or 28s-f ahow traumstic event, the Medical Examinar must be noutled at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or Rema 23s any Injury or other trauments assets.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medical þ Completed

Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

25. Was casa reterred to medical exeminer?

31. Date filed (Month, Dey, Year)

1 Yes 2 No

27. Menner of Death

Prematurity Due to (or es e consequence of):

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or in heart failure. List only one cause on each line.

Due to (or as a consequence of): Due to (or as a consequence of):

Pert II. Other agnificant conditions controlling to death buying resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24e. Was en eutopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

Approximete Interval Between Onset and Death

1 Yes 2 No

1 ☐ Yes 2 ☐ No

2	6. Place of Death (C	heck only one)	
r:	4 ☐ Nursing Home	5 Residence	6 □Other (Specify)

al	1 Impatient 2	ER/Outpatient	3 🗆 0	DOA	Other:	4 Nursing	Home	5 Residence	6 □Other (
a.	Dete of Injury (Month, Dey Year	28b. Time of Injury	М		Injury et Work? 1 Yes	2 🗆 No	28d.	Describe how inju	ury occurred

1 ( Natural 5 Pending investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

(Check only one)			s of examination	Ige, death occurred at the time, date end plece, end due and/or investigation, in my opinion, deeth occurred at the	
29b. Signature and	d tille of certifier	//		29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who co

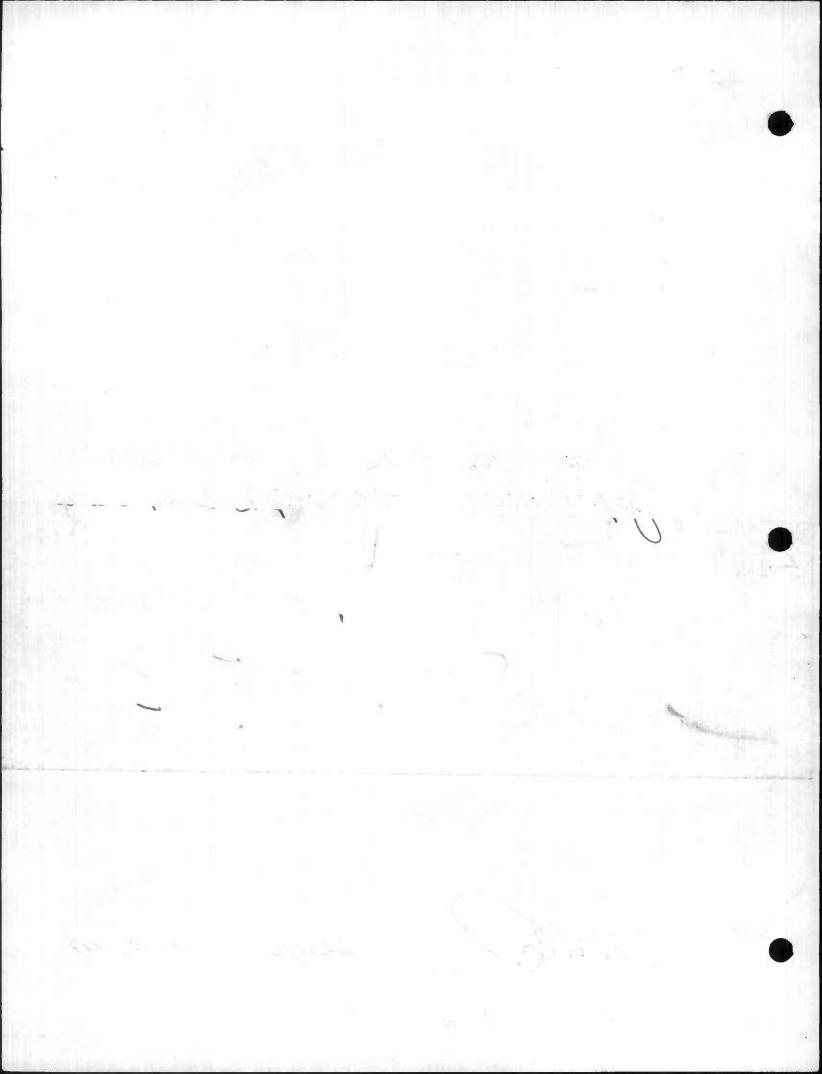
me Cloud

Hospital:

fed cause of death (Item 23a) (Type, Print) HAI DEINE Cheverly, mo 2018

State Registrar

32. Registrer's Signeture



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20bperHOSP,#29d perPhyG780 2/9/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0100 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Adventist Hospital ROCKVIILE If Under 24 Hrs. 8. Date Montgon ery 9. Birthplace (State or Foreign Country) 5. Social Security Number GROVE 7. Age (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Day, Year) Days Hours Min 10M 20 F Months MD NONE 10e State 10b Count 10c. City, Town or Location 10d. Inside City Limits 18 Yes 2 No Air MD Mount ederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 ROAD Bottom USA 3403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INFANT INFANT 0 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) KichARD R. Stiffler ANgelA NOAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13403 ANGELA N 20a. Method of Disposition Mount Airy Md. 2/ Date 20c. Location - City or Town, State Bottom Rd md. 21771 NOAH 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Decremation 3 Removal from State 9 Rockville 9/23/99 Grove Adventist July 13 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death)

Physician /Medical Examiner

physician and s the burial-transit

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certificate

After this

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun

Be

Certification: To

edical

The law requires that the death certificate be axecuted

Box 68760.

P.O.

of Vital Records.

Division or Attending **Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Ввети 23а

natural, or

permit. Pages 1 and 2 should be fised within 72 Department of Health and Mental Hygiene. Important if flam 27 is marked other than "neta any injury or other traumade event."

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

To

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Completed

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical axaminer?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

miner: On the basis of exar and manner steted. (Check only one) 29b. Signature and title of certified

Hospital:

5 Pending investigation

6 Could not be

29c. License numbe

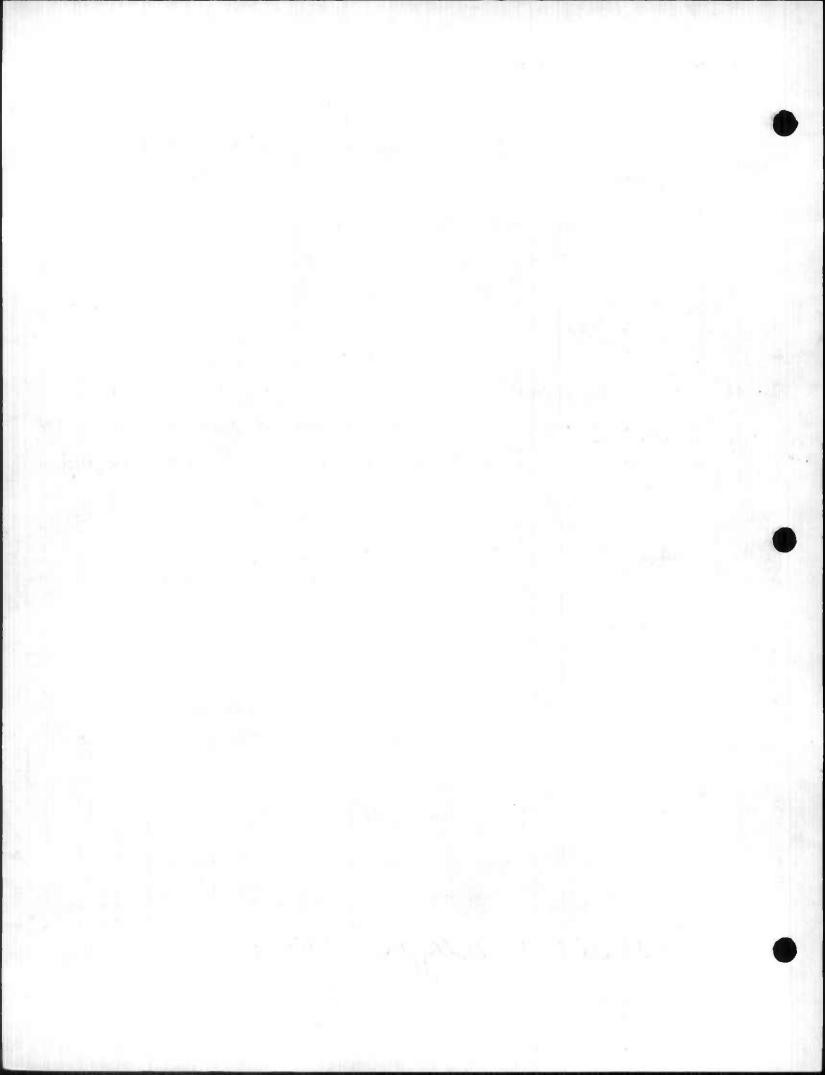
mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 1/26/2000

30. Name and address of person who completed cause of death (Item 24a) Type. Print)

99 Center De Rockville md. 20850 Mamersley 31. Dete filed (Menth, Day, Year) 32. Registrar's Signature FEB 2000 9 0

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#20bperHosp,#29d perPhyG780 2/9/2000 EW 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0100 NOAH 1 WIN -99 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Rockville /// If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) GROVE Adventist Hos. Montgomery 8. Birthplace (State or Foreign Country) Shady 6 5. Social Security Number P + A 6. Sex Funeral 10 M 200F Months Days Yrs. NONE m Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-fahow ZETes 2 No Director rederick Air Mount 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò death with permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items 23a any Injury or other traumatic avent, the Medical 13403 Bottom ROAD 21771 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Aq White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) INFANT 0 INFANT 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be KICHARD St. ffler NOAH ANGELAR. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19s. Informent's Neme/Ralationship (Type, Print) 3403 Mount Airy Md. 21771 20c. Location - City of Town, State Bottom ROAD NOAH ANgelA 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Mathed of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Kockville GROVE Advent 22. Name end Address of Facility Adventist 9-23-99 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximeta intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition rasulting in deeth) Examiner Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and Due to (or as e consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the a Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate director, Be 25. Wes case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospitel: 1 Yes 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA edical Certification: To funeral 28a. Date of Injury (Month, Dey Year) 27, Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Director: After in by the funer 1 Neturel 5 Pending To the Hospital or within 24 hours after death. To the Funeral Director: After membershiftlied in by the fur 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida

State Registrar 29a. Certifian

(Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Day Year)

Sheri Hamersley

FEB

L. Hamersen

MD

32. Registrer's Signatura

30. Nema and address of parson who completed cause of deeth (fem 23a) (Type, Print)

0 9 2000

**DHMH 16 Rev 6/95** 

(a) Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(a) and manner as stated.

medical Center

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and menner steted.

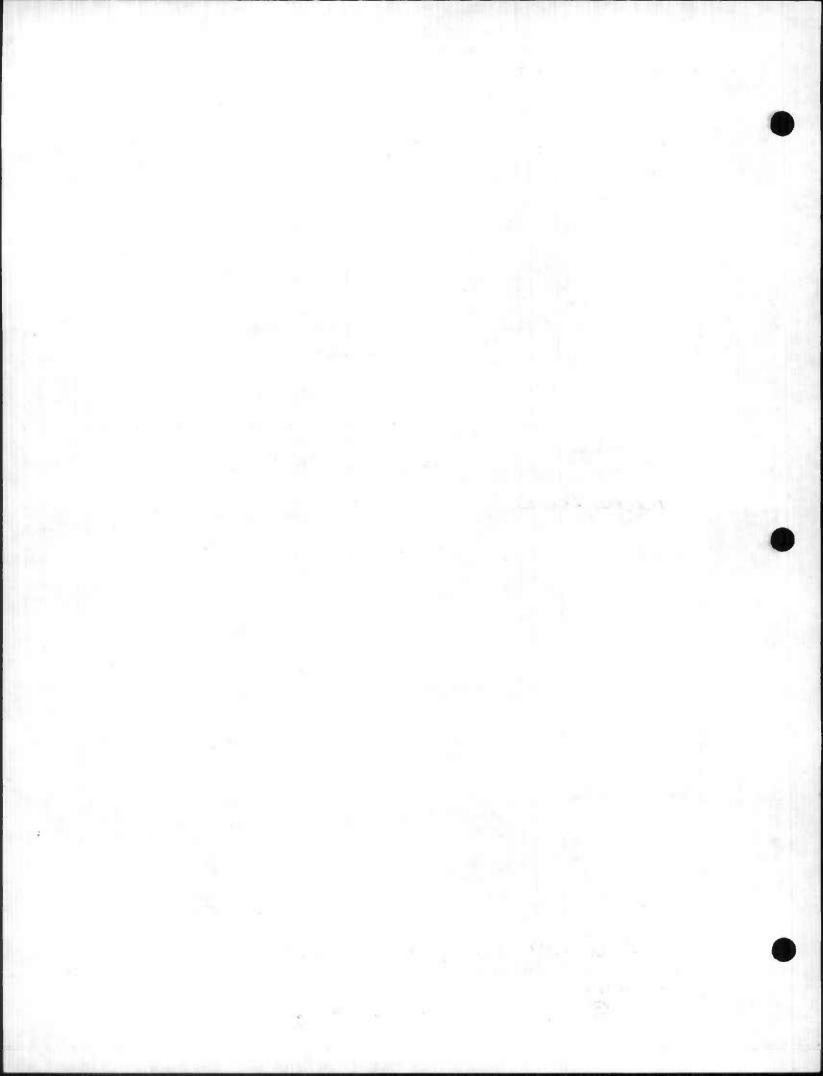
29c. License number

Day Ent

29d. Data signed (Month, Day, Year)

1/26/2000

DR. Rockville, ma 20850



State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Amended Item#20b perFHG780 2/9/2000 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Physician NEELY NICOLAS GARETH Deptember 6, 1999 4b. City, Town, or Location of Death 4c. Country of Death 03:46 /Medical 4a Facility Name (If not institution, give street and number) Examiner Rockville
If Under 24 Hrs. 8. Dete of Birth
Min. (Month, Day, Year) MONTGOMERY COUNTY 5. Social Security Number st Hosp; tal.

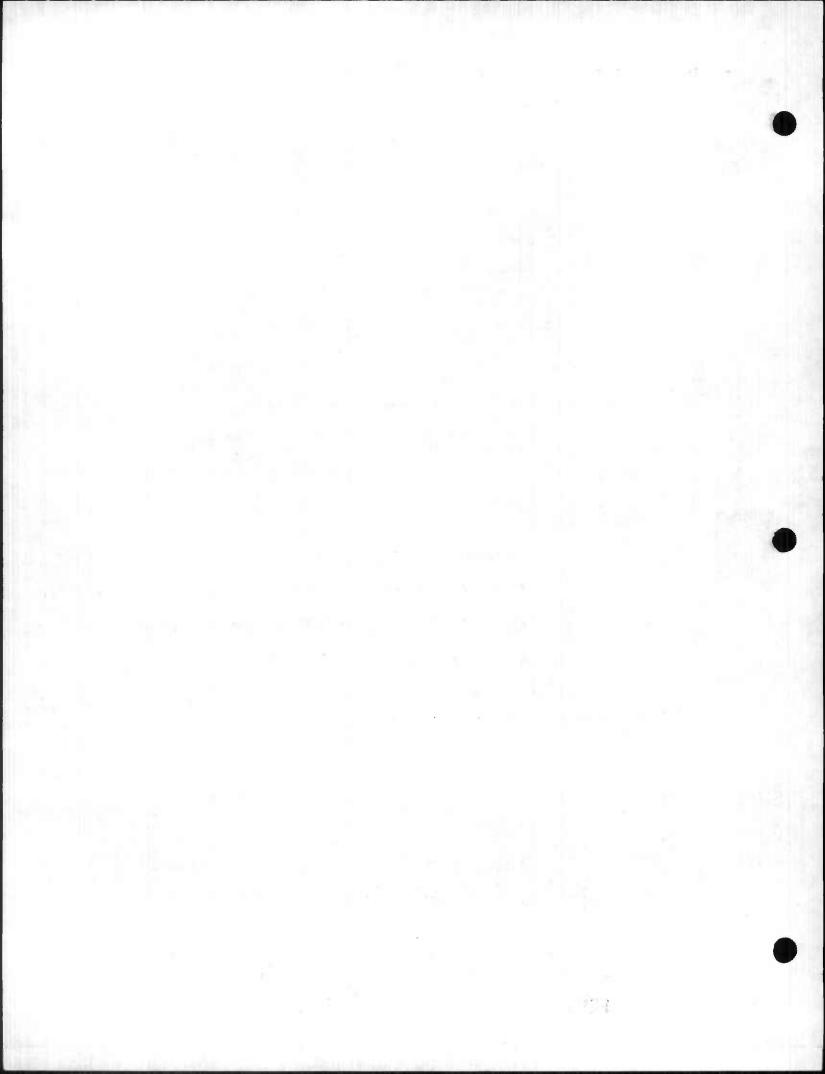
7. Age (In yrs. lest birthday) Adventist If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 1 M 2 F **Funeral** Days Months IN FANT
Usual Residence of Decedent Director August 25, 1999 MARYIANd 10s. State 10c. City, Town or Location worle 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itama 29a or 28a-f sho troumatic event, the Medical Exercitors must be notified at Silver Spring 1 Yes 2 No Director MARYLAND MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? 20904 USA permit. Pages 1 and 2 ahould be filed within 72 hours effer death v Department of Heelth and Mental hyglene. Important: If Item 27 is marked other than "natural", or handlesy lightly or other treumatic event. 305 Funeral ANC 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced BlACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To William Neely Nicole 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring md. 20904
Dete 20c. Cocation - City or Town, Stele Nicole Neely MimosA LANE 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State Adventist 3-6-2000 4 □ Donation 5 □ Other (Specify) GROVE 21. Signature of Funeral Service Licensed 22. Name end Address of Facility lases Shady Grove Adventist la 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PREMATURI EXTREME DAYS Examiner Physician/Medical Examiner SEUDOMONAS ettending physician and i for use as the buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): INTRAVASCULAR COAGULOPATHY 3 DAYS DISSEM INATED Box 68760 Due to (or as a consequence of): ENTERO COLITIS P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2⊠No 3 Probably 4 Unknown HEMORRHAGE MONARY of Vital Records, Be Completed by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Nes 2 □ No 1 Yes 22 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 th: After this To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie world 50453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Di FAZIO 77d 9901 Medical Rockville md. 20850 Center Dr. Terri

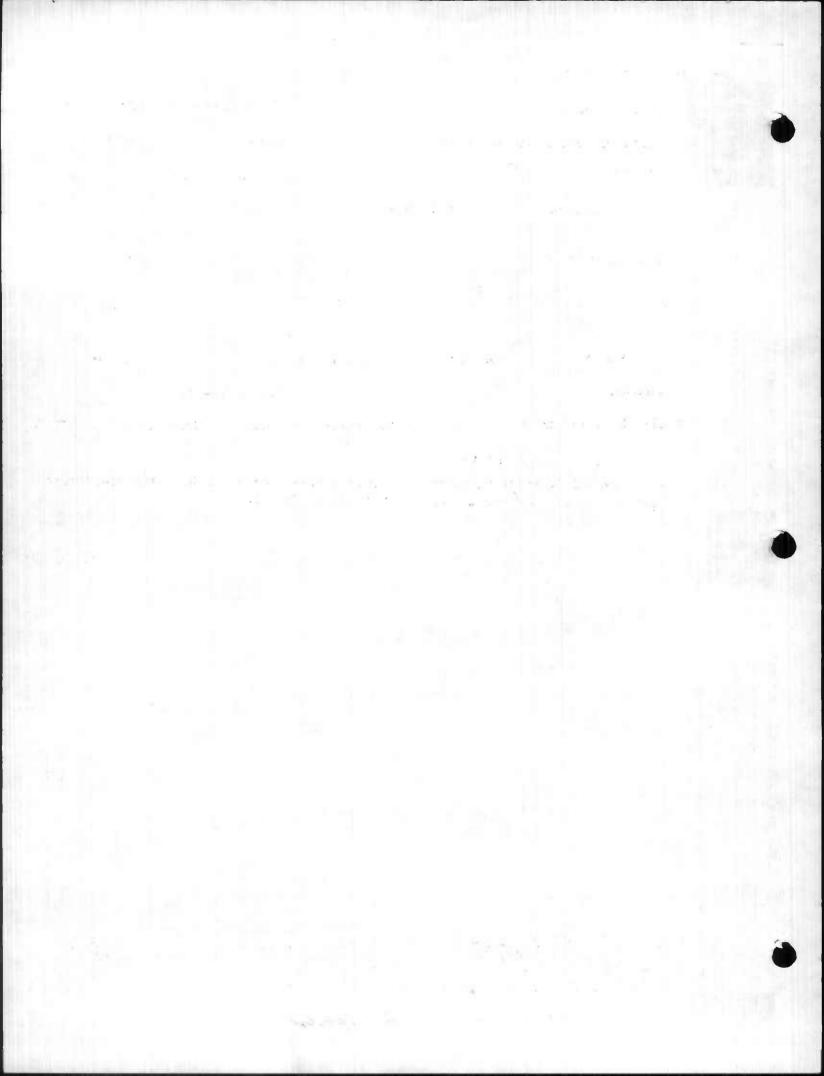
**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Par Bar) 9



	I tem#25,27 perPhy 1. Decedent's Name (First, M		9/2000 E	W	Cer	tifica	te of l	Death	2. Date of D	Reg. No.	2 2 1		of Death
cian	Thelma O. Rot								Month Decemb	Dev	1999		5 AM
ical iner	4a Fecility Neme (If not institu	ution, give s					4	b. City, Town,	or Location of Dea		nty of Death Howard		
	Lorien Colu 5. Social Security Number	mbla 6. Sex		Age (In yrs.	last birthday)	If Unde	r 1 Yeer	If Under 24 h	irs.   9 Date of B	irth	9. Birthpl	ace (Stat	e or Fore
	216-09-4809	M 2X F 95 Yrs. Months Days Hou			Hours M	May 9	9ay, Year) 1904	Year) Country)					
	Usual Residence of Decedent  10e. State 10b. Cou	unty		10c. City	y, Town or Local Lumbia	ation					10	Dd. Inside	City Limi
Director	MD Hov	ward		Co.	Lumbia							1 🗆 Y	es 2DN
5	10e. Street end Number			- 70		10f. Zi	p Code			10g. Citizen o	of Whet Coun	try?	
	6334 Cedar I		2. Was Decede	nt Ever in II	S 13 W	Vas Dece	ident of H	21044	(Specify Yes or N		JSA ace - America	an Indian	
	1 Never Merried 2 N	Married	Armed Force  1 Yes 2  If Yes, Give  Year or Dete	os? () No			2 No	Specify:	(Specify Yes or Nuerto Rican, etc.)	Spec	lack, White,	etc.	
	15. Dece (Specify only hi	dent's Educ	ation completed)		16a. Deced	kind of w	ork done o	during most of I	working	16b. Kind of	Business/Ind		
ŀ	Elementary/Secondary (0-1		College (1-4		life. D		ise retired						
	unknown 17. Father's Name (First, Midd	dle, Last)	unk	nown		ho	usew		Name (First, Middl	le, Maiden Sum	own h	ome	
	unknown							Si	lvia Was	tler			
Ì	19a. Informant's Name/Releti				19b. Mallin	g Addres	s (Street		Rural Route Num		vn, State, Zip	Code)	
	Thelma Milter  20a. Method of Disposition  1 Burial 2 Cremati	ion 3 🗆 Re	moyal from Sta	ate C	556. Place of Disposementery, crem	sition (Na	me of		rch Rd,		stle P. n - City or To		
4 □ Donation State (Specify) In State									Board 655 W. Baltimore Street 21201				eet
	shock, or heart tailure.  Immediate Cause (Final disease or condition resulting in death)	a.	e cause on eac	Sev	r as a consequ			entia				Onset er	Between and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>f</b> b		Due to (o	r as a consequ	uence of	:				1		
	Cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	C.		Due to (o	r as e consequ	uence of)	:				1		
	Part II. Other significant con-	ditions cont	ributing to deat	h but not res	ulting in the un	iderlying	cause giv	en in Part I.		d tobacco uss	/		es of dea
									24a. Wa	as an autopsy formed?	ave	ere autop eileble pri mpletion death?	ior to
									10	Yes 20 No	10	Yes 2	No No
							Oth	-	Death (Check only	y one)			
מ	25. Was case referred to med examiner?	-	and the land		ER/Outpatient	1 3□ 0		4 Mursin	g Home 5 □ Re	sidence 6 C		y)	
200	examiner? 1 ☐ Yes 2 ☒ No	-											
Io Be	examiner?  1 Yes 2 X No  27. Manner of Death 1 Natural 5 Per 2 Accident Inv 3 Suicide 6 Co	Н	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	М		k? Yes 2□No	28f. Location	(Street and Nu	mber or Rura	I Route N	lumber,
Certification: 10 be	examiner?  1 Yes 2 X No  27. Manner of Death  1 Natural 5 Pe  2 Accident Inv  3 Suicide 6 Co  4 Homicide	nding restigation uid not ba termined	28a. Date of (Month,	Injury Day Year) Injury - At ho, etc. (Specified)	28b. Time of Injury	M eet, facto	1 ☐ ry, office	Yes 2 □ No	28f. Location City or 7	(Street and Nurown, State)	manner as si	tated.	
edical cer micanom. 10 De	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pe  2 Accident  3 Suicide 6 Co  4 Homicide  29a. Certifier (Check only one)	nding estigation uid not ba termined lifying Physical Examin	28a. Date of (Month,	Injury - At ho, etc. (Specification of my knows of examina	28b. Time of Injury	M eet, facto occurre estigatio	1 □ ry, office d at the tir n, in my o	Yes 2 ☐ No	28f. Location City or 7	(Street and Number (State)  e cause(s) and e, date and place	manner as si	lated.	se(s)
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#15,16a-b,17 perKBG780 2/9/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 10:30 AM Baly quil November 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Hezith Care Baltimore Baltimore Cit Sount Agnes If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Hours 1 M 2 F Months Days Min. MIA Yrs. Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zlp Code Walrad Street 21229 AZU 4011 12. Was Decedent Ever In U.S. Armed Forces?, 1 Yes 2 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantery/Secondary (0-12) Collaga (1-4or 5+) Infant Infant MA 17. Father's Name (First, Middle, Last) 18 Mother's Nama (First, Middle, Maiden Surneme) Michael Theodore Bennett KOSS ramela 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 18a. Informant's Name/Relationship (Type, Print) mother Pamela L. Ross Walrad Baltimore old 21229 110 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 Burlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Baltimore, Md agues Health Care Hd 21229 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Stagues fleathCare 900 Coton Ave Cathy Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. tmmediata Causa (Final 5. Shours diseesa or condition rasulting in deeth) respiratory Due to (or es e consequence of): 11 hours hysline membrane disesse severe Due to (or as e consequence of): 11 hours Due to (or as a consequence of): extreme Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed

To the Hospital or Attending Physician: the lan required within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the ecompletely filled in by the funeral director, page 2 should be deteched from the funeral director, page 2 should be deteched from the funeral director.

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Be

10

Certification:

edical

P.O. Box 68760,

Division of Vital Records,

Barry

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Rema 23a

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the Medical Examiner must be notified at

Funeral

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the Marylend

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner ettending physician and for use es the buriel-tran Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Physician/Medical

1 Yes 2 No 3 Probably 4 Unknown

preumothorax

24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 PNo 1 ☐ Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 2 No

Hospitel: 1 Inpetient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Daath 1 DNatural 5 Panding Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 | Homicide

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Cartifian

1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and piece, end due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the tima, date end place, and due to the ceuse(s)

29b. Signeture end title of certifier I duson m. Idropiro ma remetologist

end manner steted.

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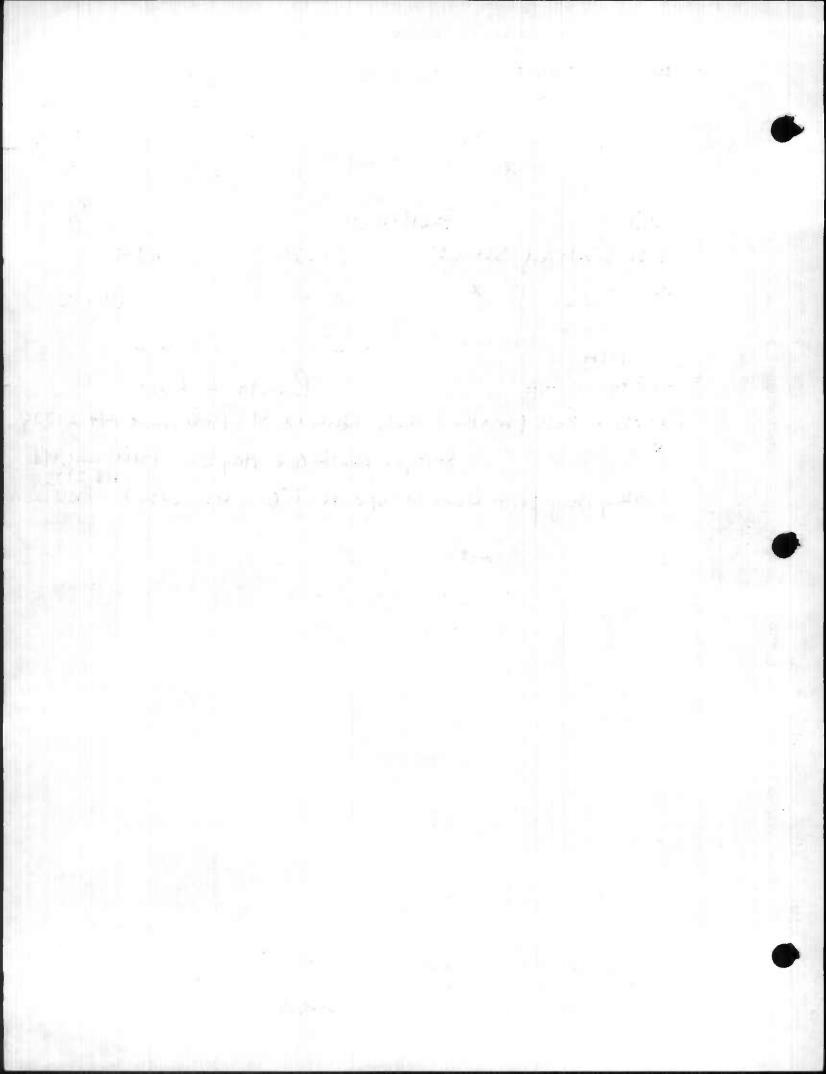
29c. License number

29d. Date signed (Month, Dey, Year) November 13, 1999

30. Nama and addrass of person who complated ceusa of daeth (Item 23e) (Type, Print)

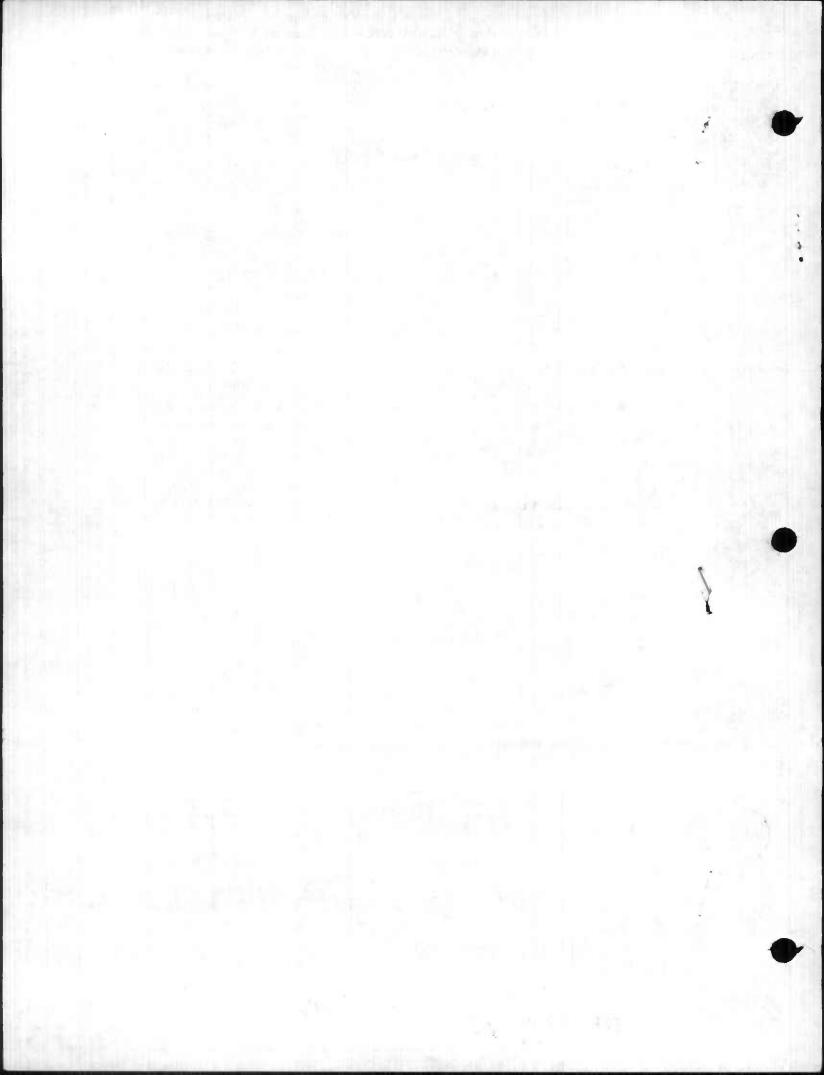
Susan M. Schapiro MD, Sount Agnes Health Care, 900 Cuton Arenue, Baltimore MD 21229 31. Data filed (Month, Dam York) 0 9 2000 Registrar's Signature

State Registrar



Division of Vital Records, P.O. Box 68760, To the Hospital or Attaching Physician. The law inquires that the death certificate be executed within 24 hours after ofaith.  To the Funeral Director, Allis this destinate has been signed by the attending physician and	x 68760,	artificate be executed	Sing physician and
Division of Vital Reco	ords, P.O. Bo	equires that the death o	en signed by the attend
Division of To the Hospital or Attaching P within 24 hours after of afth. To the Funest Director Alls of	of Vital Reco	Polician: The law ra	his dentificate has be
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0	1514 S.		LPHIA BLV	_	s. last birthday)	If Under 1 Yaar	ABERD	Hrs   e Date of E	tieth	FORD	on (State or English
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	Usual Residence	e of Decedent		100 6	City, Town or Lo	postion				104	In old o City I imite
6	100		: 1			Cation				100.	Inside City Limits  1 XYes 2 □ No
2000	10e. Street and I		L <u>L</u>	1 -	Elkton	10f. Zip Code		1	10g. Citizen ot	What Country	?
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		is larried 2 Marr d 4 Divorced	Armed F	2 No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No		7 (Specify Yes or Puarto Rican, etc.)	Ble	ce - Amarican eck, White, etc.	
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	17. Father's Nam	ne (First, Middle,	Last)					Name (First, Midd			prex
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		Name/Reletions						or Rural Route Num			ode)
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	1 Burial		3 Removal from	State	cematery, cres	matory or other pla st Method		m.1/5/00			Maryland
		Funeral Service			2	2. Name and Addre	ess of Facility	Europa	D 2		
	1		2.4.	625				unerals, P.A. St., Elkton, MD 21921			
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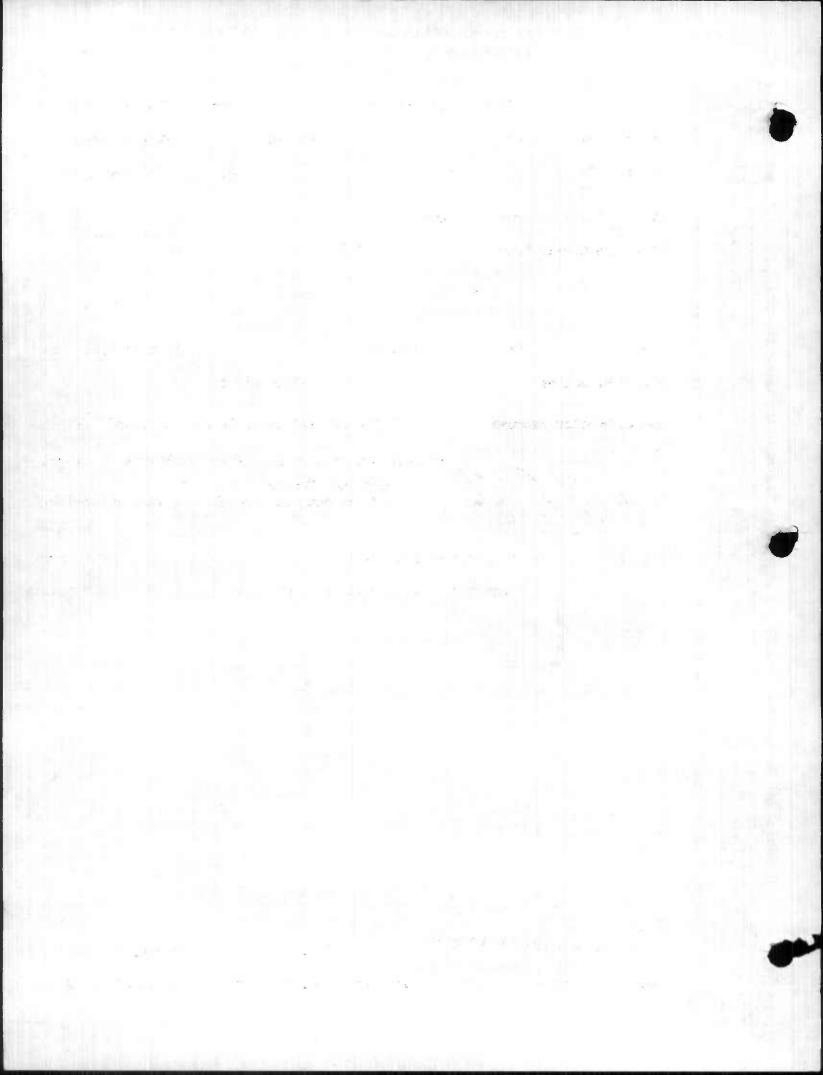


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Dete of Death De Month **Physician** Phyllis Ann Webster December 31, 1999 11:15 am /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** 1□M 2 F Months Days Hours Min. Yrs. 096-32-6166 60 Jul 21, 1939 Director New York Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Prince George Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 늄 6403 Forest Mill Lane 20707 USA permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, he Medical Examine mustle once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: pA 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Special Education 18 Mother's Name (First Middle Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Edward H. Potter Alice O'Hare P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald Webster /spouse 6403 Forest Mill Lane, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/00 Columbia Memorial Park Columbia, Maryland 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory arrest, only one cause on each line. 23a. Part1. Enter the chasse, shock, or heart shiften. Approximate Interval Between Onset and Death **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Respiratory failure 24 hours Examiner Due to (or as a consequence of) Examiner Metastatic renal cell carcinoma 3 months The law requires that the deeth certificete be axecuted attending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. the 2 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 反 Unknown signed t Records, by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? Deed completion of cause of death? has 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificata Division of Vital Physician: director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L<sub>o</sub> 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation or Attending 1 XNetural 1 Yes 2 No after death. Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 the 29b. Sign hurs end title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) 0 Stell. 0 D23743 January 01, 2000 15 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Martin D. Weltz 7525 Greenway Center Drive, Greenbelt, Maryland 20770 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State JAN 0 4 2000 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

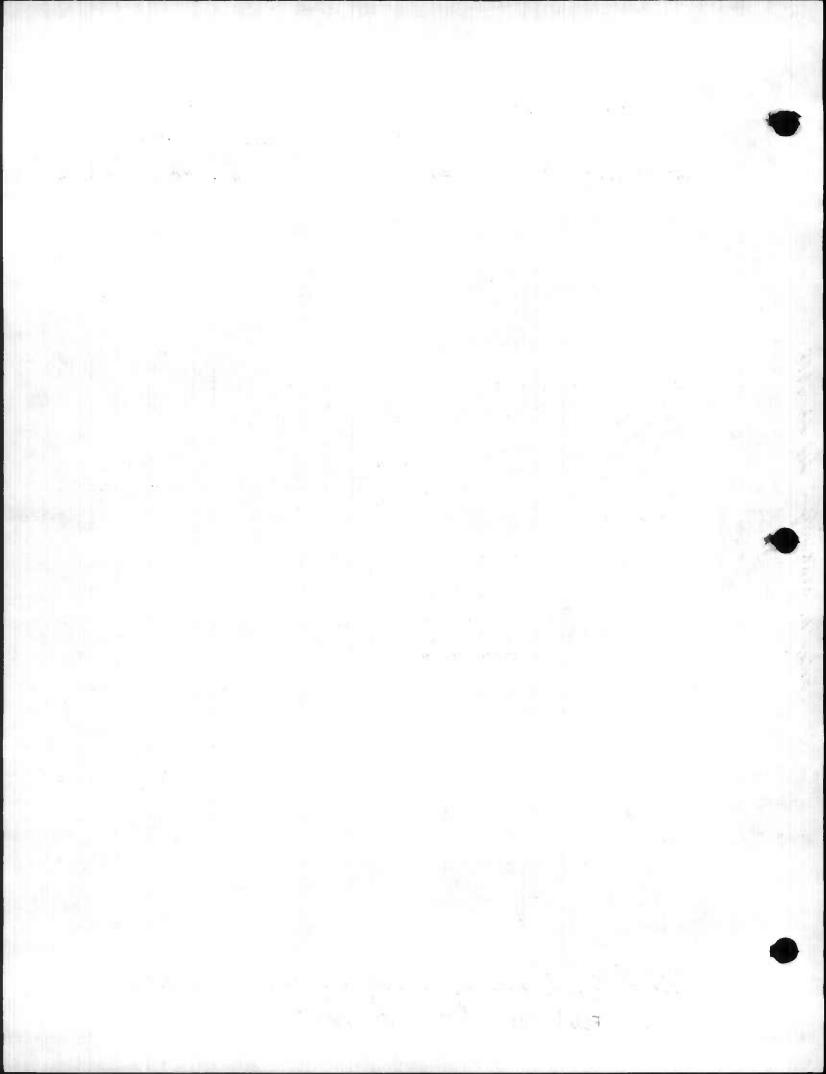
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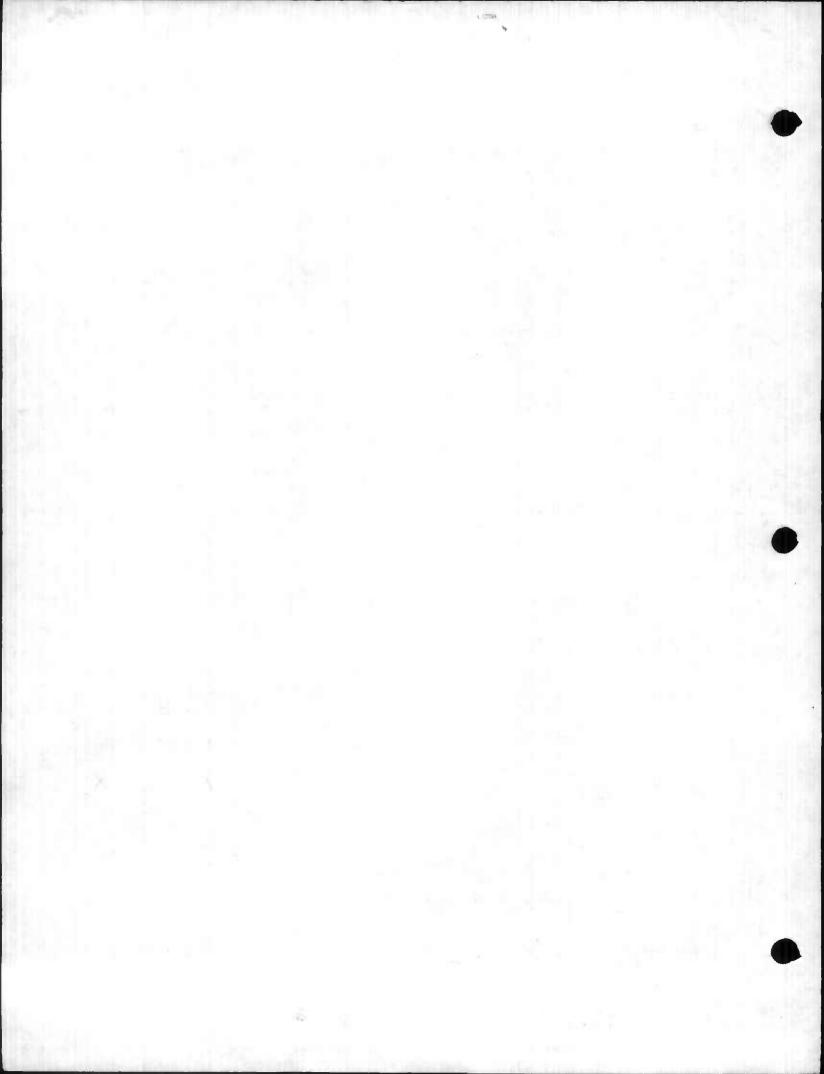
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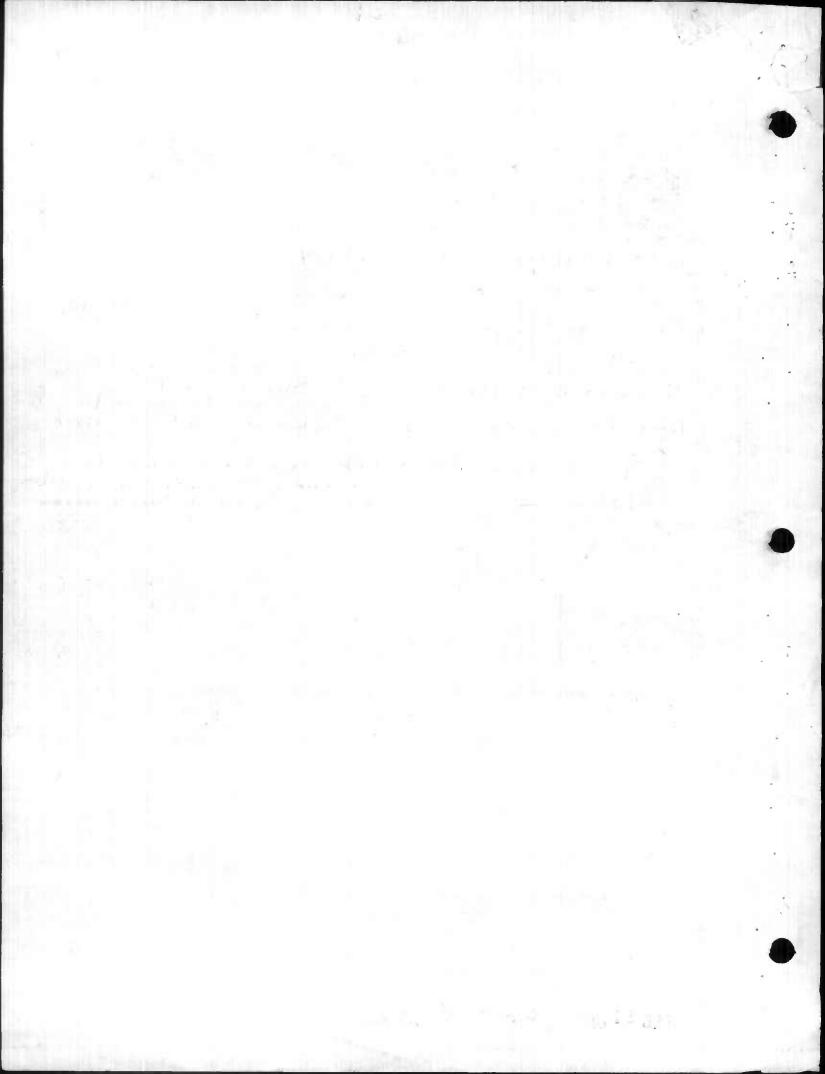
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miner	PENINSULA REG		CAL CENT	ER		SALISB		WICO			
	5. Social Security Number 6. 5		In yrs. last birtho	(ay) If Under	er 1 Year	If Under 24 H		irth lay, Year)	9. Birthplace (State or Fo Country) Maryland		
	Usual Residence of Decedent  10a. Stete 10b. County	11	Oc. City, Town o	r Location					10d. Inside City Li		
tor	Maryland Wicomi	co	Fruit	land					1 XYes 2		
Director	10e. Street and Number 110 Williams Av			10f. Z	ip Code 21826	-		10g. Citizen of V	What Country?		
by Funeral	11. Merital Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	Ever in U,S. 13. Wes Decedent of Hispanic Orig H Yes, specify Cuban, Mexican				(Specify Yes or Nerto Rican, etc.)		e - American Indien, ck, White, etc.		
		(Specify only highest grade completed)				tion uring most of t	working	16b. Kind of B	usiness/Industry		
•	Elementery/Secondery (0-12)	College (1-4or 5+)	**	le. DO NOT	uso romou)			Seafo	od Industry		
Paradimon on o	17. Father's Neme (First, Middle, Last)  16. Mother's Nam							Name (First, Middle, Meiden Sumeme)			
3	Jacob Kilraine S	terling				Eutl	ha Mae St	cerling			
Department of Health a Important: if Item 27 is eny injury or other trainings.	19a. Informent's Neme/Reletionship ( Constance Sterli						Rural Route Num Fruitlar				
	20a. Method of Disposition  1 □ Burial 2 □ Cremetion 3 □  4 □ Donation 5 □ Other (Specif			crematory or	other place		Date 12/15/99		City or Town, Steta		
	4 Donation 5 Other (Specify)  21. Signifium of Funeral Service Licensee  22. Name and Address of Facility Holloway Funeral Home Professional As 501 Snow Hill Rd., Salisbury, MD 2180  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.										
	Immediate Cause (Finel disease or condition resulting in death)  CONGESTIVE HEART FAILURE  Due to (or as a consequence of):								Interval Between Onset and Deat		
Examiner	_		OBESITY						YEARS		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Di.	e to (or es e cor	or es e consequence of): YPOVENTILATION SYNDROME					YEARS		
	that initieted events resulting in death) Last	CDu	Due to (or as a consequence of): ERTENSION						YEARS		
The second second	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  DIABETES MELLITUS							23b. Did tobacco use contribute to the contribute 1   Yes 2   No 3   Probably			
completed by							24a. Was an autopsy performed?		24b. Were eutopsy finding aveilable prior to completion of cause of death?		
							10	1 Yes 2 No 1 Y			
Be	25. Was case referred to medical examiner?						Death (Check only	one)			
ition: To	1 Yes 2 No  27. Manner of Deeth  1 Netural 5 Pending 2 Accident investigation				28c. Injury Work	Other: 4 Nursing Home 5 Residence 6 Other (Specify)  njury at Nork?  Yes 2 No					
Certification:	3 Suicide 6 Could not b determined	288. Piece of injury	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Nu City or Town, State)			
edical											
M	E 29b. Signature and title of certifier 29d. Date signed (Mont.										
	1	ton			D 2498C Te DV. SOLISHIY, M.			12/1	3/99		



State of Maryland / Department of Health and Mental Hygiene 0 0 1.2060

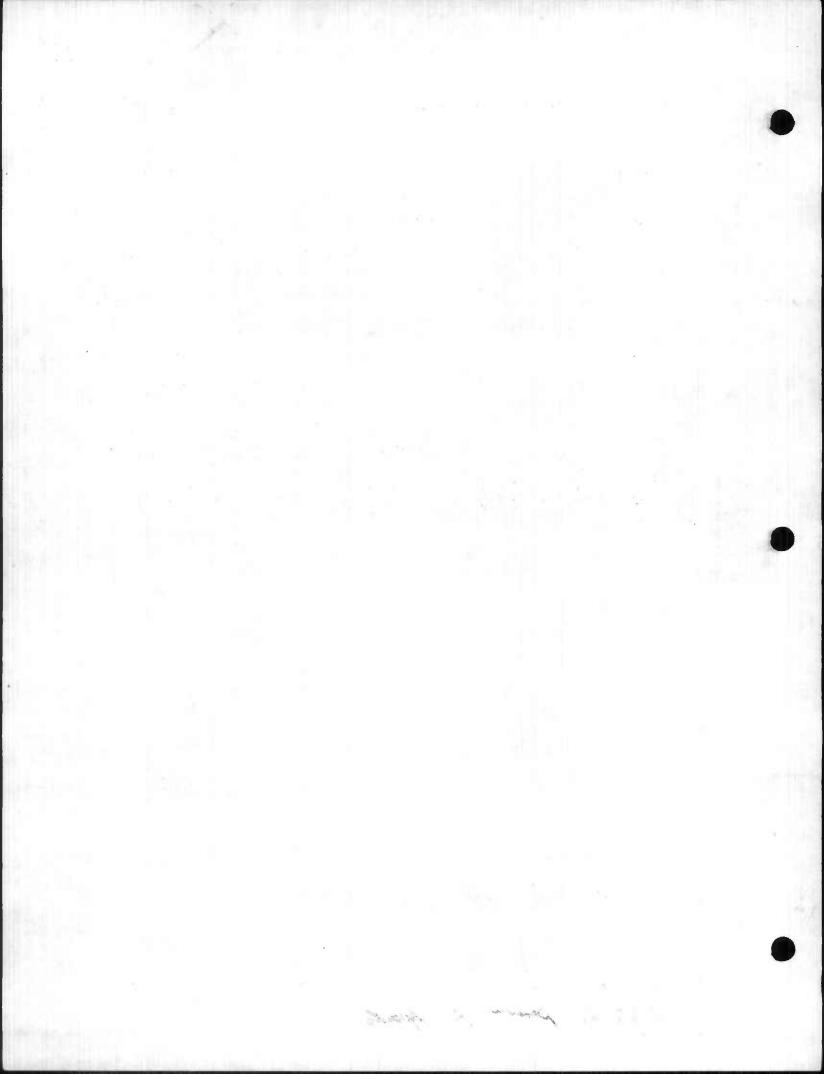
	1. Decedent's Name (F.	Total Addition & co.												
	1. Decedent's Name (r.	Irst, Middle, Las	st)							2. Date of D Month	eath Day	Year	3. Time	of Death
sician edical	GEORGE V	WILLIAM	BANADI	0						Decemi			6:0	O A.M.
miner	4a Facility Name (If not	t institution, give	street end nu	mber)				4b. City, T	Town, or Lo	ocation of Dea	th 4c. Co	ounty of Death		
	Universi								altim			N/A		
	5. Social Security Numbunknown		ex M 2□F	7. Age (In yr.	40 Yrs	Month	dar 1 Yaar ns Days	Hours	Min.	8. Date of Bi (Month, D Aug 22,	irth ey, Year) 1959	9. Birth Cou	intry)	e or Foreign nknown
	Usual Residence of Dec 10a, State 10	b. County		10c. C	City, Town or	r Location							10d. inside	City Limits
0	unknown	unl	known			nknowr							,10Y	es 2 No
Directo	10e. Street and Number		KIIOWII		uı		Zip Code				10g. Citizer	n of Whet Cou	inknov	VII
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Funeral		nknown	12. Was Deci	edent Evar in	U,S. 1	13. Was Dec	cedent of I	Hispanic C	Origin? (Sp	ecify Yes or N		Race - Ameri		
	1 Navar Married	1000	Armed For 1 Test Yes, Gir Year or D	2 No	own		pecify Cub			Ricen, etc.)	Sp	Black, White, pecify: Wh		
Be Completed		. Decedent's Ed			16a. De	ecedent's Us	sual Occup	pation	ant of work	ina	16b. Kind	of Business/Ir	ndustry	
ď.	Elementery/Seconda	only highest gre ary (0-12)	College (	1-4or 5+)	life	iva kind of the DO NOT	Tuse retire	d)	Jat OF WORK	m ig				
-	unknown		unk	nown		1	unkno	T				unkno	wn	
100	17. Father's Name (Firs	st, Middle, Last)						18. Mot	her's Nam	e (First, Middle	e, <i>Maiden S</i> u	meme)		
	unknown									known				
	19a. Informant's Name	/Relationship (7	Type, Print)							al Route Num			ip Code)	
	O.C.M.E.	A'		00h	Place of Di	l Penr		eet	Balt:	imore,		1201	our Ctate	
	20a. Method of Disposit  1 ☐ Burial 2 ☐ C  4 ☐ Donation 5 ∑	remation 3		State		cremetory o		ice)		Date	200. 2009	tion - City or T	Own, State	
	21. Signature of Euners J OS	al Salvice Troes	Van San	t1 4	/	CA-Name	Anat	Ollivag	Board	655 W	. Balt	imore:	Stree	
	33a Part Entar the d shock, or heart fa	disease, or comp illure. List only	an A	ent		Balti	more,	MD	2120	1		1	Approxir Interval I Onset a	nate
/Medical Examiner	23a. Part II Entar the d shock, or heart fai	disease, or compiliure. List only of the compilium of the	b. Com	be used the de lach line.  Ly Liv Due to	ath. Do not	Baltinenter tha mand Pusequence of	more, noda of dyi	MD ing, such a	2120 as cerdiac	1			interval l	nate Between
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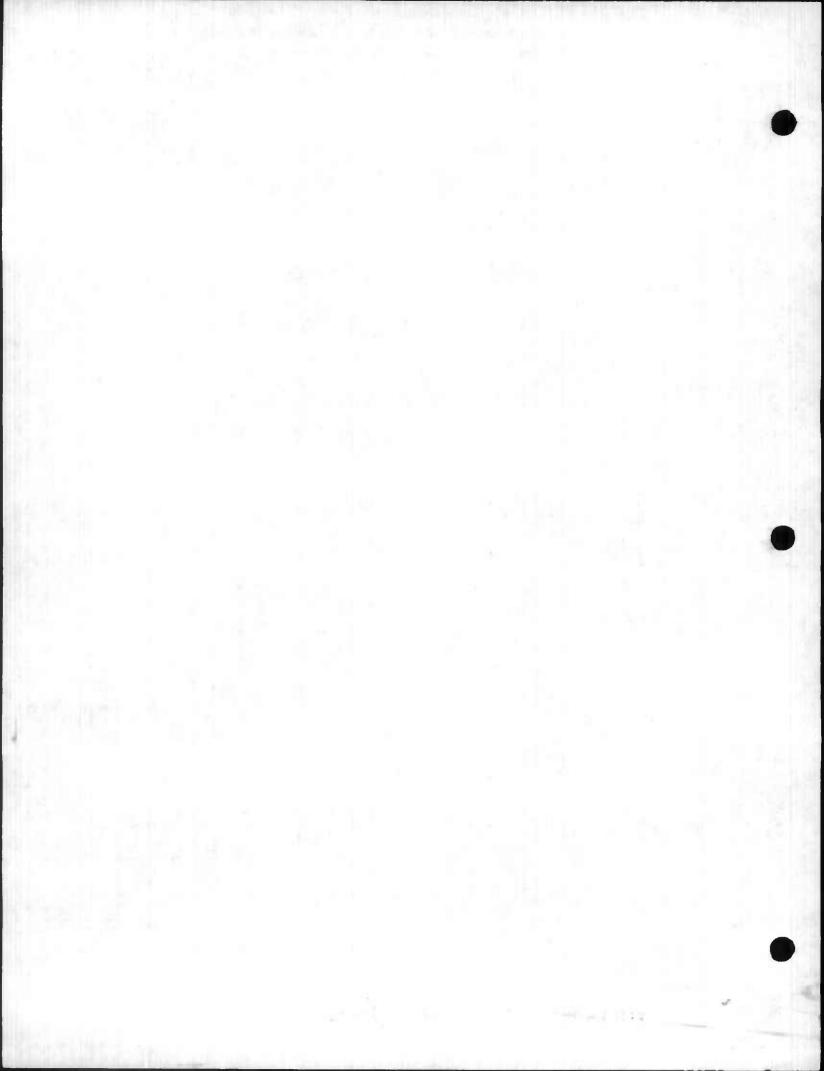
State of Maryland / Department of Health and Mental Hygien 9 4 2 8 7 1

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Medical			MASON	)	4. 65. 7	AUG.			
aminer	4a Facility Neme (If not instituti					or Location of Dea			
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eral ctor	5. Social Security Number	6. Sex 7. /	Age (In yrs. last	Yrs. Months		in (Month, D		9. Birthplace (State or Foreign Country) MAKYLAND	
	Usual Residence of Decedent  10a. State  10b. Count	h.	100 City T	own or Location				Jacob specials City I imite	
ector					_			10d. toside City Limits	
Sch	MARYLAND PRIN	E GEORGES	LHA	300062			10g. Citizen of What Country?		
al Dir	10e. Street and Number 1725 BUCO	SIDE ROAD					10g. Citizen of W		
by Funeral Director	11. Merital Stetus  1 ☑ Never Merried 2 ☐ Me 3 ☐ Widowed 4 ☐ Divorce	Armed Force 1 Yes 2 I	12. Was Decedent Ever in U,S. Armed Forces?  1  Yes 2  No H Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2☑ No Specify:			- American Indian, k, Whita, etc.	
To Be Completed		ent's Education	de completed) (Giv life.		ual Occupation work done during most of w	undring	16b. Kind of Bus	siness/Industry	
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e C	17. Father's Name (First, Middle	The state of the s	/		18. Mother's N	leme (First, Middle	e, Maiden Sumeme	9)	
0	KENAN DOR	CELL MA	SON		NICOLE	E LEE	RAWLI	NOW	
	19a. tnforment's Neme/Reletion	nship (Type, Print)		19b. Meiling Addre	ss (Street and Number or	Rural Route Numi	ber, City or Town, S	Stete, Zip Code)	
ToBeC	PLINCE GEORGE	S HUSPITAL	CTR. 3	3001 HU	SPITAL UR	IUE CH	EVERLLY	, MD 20785	
tant of lury or o	20e. Method of Disposition  1	3 DRemoval from State	20b. Plece	e of Disposition (Nestry, commatory or	eme of	2-9-00		DICKS NO	
	21. Signardire of Funeral Service		,	22. Name of	and Address of Fecility	13C4 C	Bush	M	
	23a. Part I. Enter the disease,	or complications that calls	ad the death. [	o not onter the my	odo of thing, such as a fed	lian or respiratory	avect /	Approximate	
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edicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С	Due to (or as						
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State of Maryland / Department of Health and Mental Hygiene 9 4 2 8 7 2

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miner	4a Facility Nama (If not institution, given				4b. City, Town, or	Location of Death	4c. County	of Death	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 4e Facility Name (IT not institution, give street and number) 05:08 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove
5. Social Security Number If Under 24 Hrs.
Hours Min.

Min.

Min. Montgomery

9. Birthplace (State or Foreign
Country) Adventist 6. Sex 7. If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days INFANT 1 M 2 XF Months Yrs. Director October 27, 1999 MARY AND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Director PERMANTOWN MARYLAND Montgomer y 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò irde #34 20874 Nems 23a 00013 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Merital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hyglene. Important: if fem 27 is marked other than "natural", or fee any injury or other traumatic event, the Medical Exercise and pages. 1. Never Merried 2 ☐ Married 1 ☐ Yes 2. ☑No Specify: Baitimore, Maryland 21215-0020 If Yes, Give Year or Detes: ò 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Eric Agyerong

19a. Informent's Neme/Relationship (Type, Print) DZOVOY AtheNA Ams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20013 Sweetgun Circle # 34 Germantown Md. 20874 Athena Ac 20a. Method of Disposition Agyepong 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State Grove Adventist 11-29-99 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility 9901 Medical Conter DR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kockvillend 20850 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Due to (or es e conse Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Certification: To Be Completed 2 DNo 1 Yes 2 No 1 Yes Division of Vitai 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2DNo 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred After To the Hospital or Attending is within 24 hours effer death.
To the Funeral Director: After 1 PNeturel 5 Pending investigation 1 Yes 2 No Director: A 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 8 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29d. Dete signed (Month, Dey, Year) 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) SENG MD SHEW-SHO 9075 Abaly

DHMH 16 Rev 6/95

32. Registrar's Signature

garters a

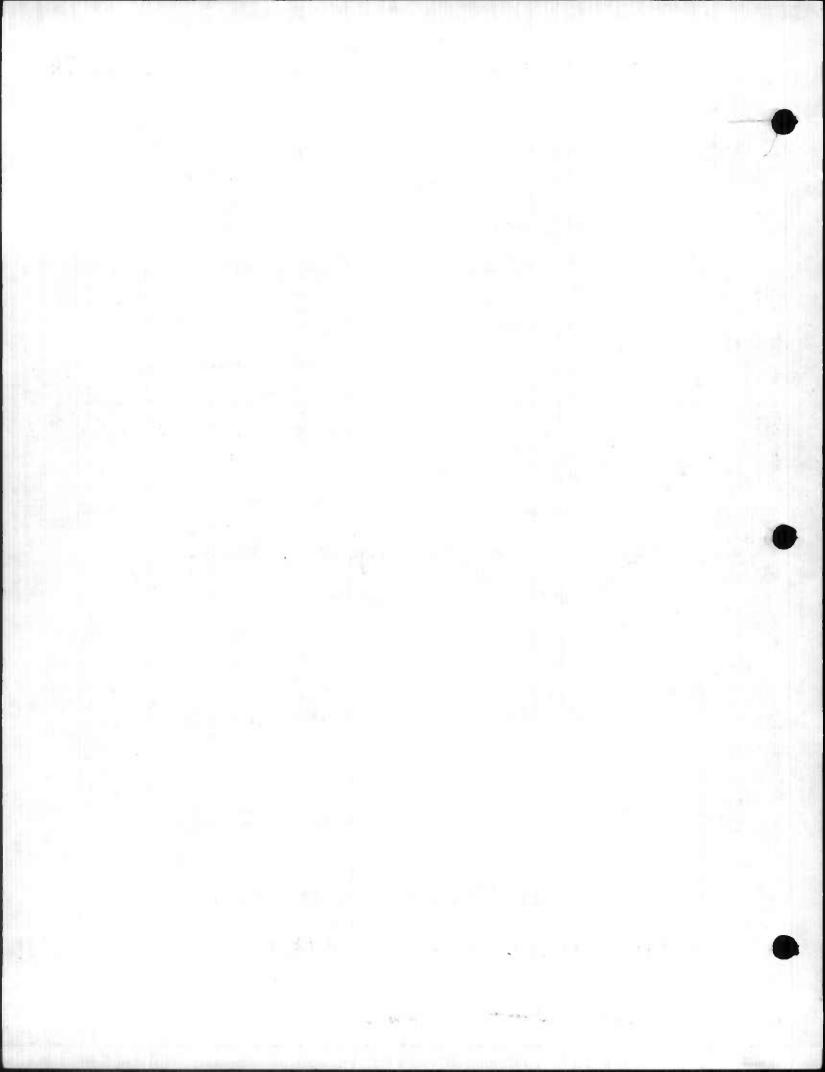
State

Registrar

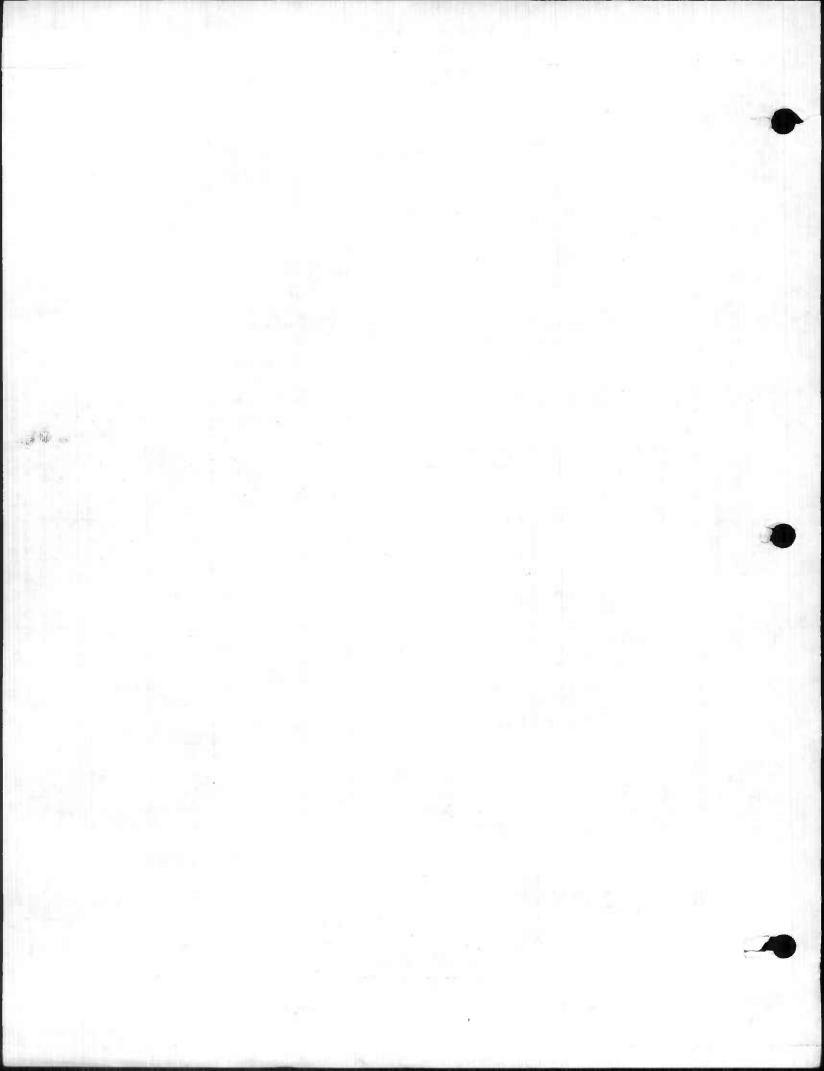
31. Dete filed (Month, Day, Year)

FEB 2 3 2000

AMEN	D#7 PER DVR G788 10-20- AMEND#7&20B PER HOSI	200 tate of Maryland / $2.6780$ 2-24-2000 JAB	Department of He Certificate of D	ealth and Menta Death	Il Hygiene Reg. No. 9 9	42874
Physician /Medical	1. Decedent's Name (First, Middle, Li		)	Mo	e of Deeth nth Dey otember 28	Yeer 1999 05:15An
Examiner  Funeral  Director	4a Facility Name (If not institution, git  Shady Grove  5. Social Security Number  6.		Hospital 40	Reckuill  H Under 24 Hrs. 8. Dat Hours Min. (Mo	of Death 4c. County	of Death  130 mery  9. Birthplace (State or Foreign Country)
ahow	Usual Residence of Decedent  10a. State 10b. County		own or Location		,	10d. Inside City Limits
death with the Maryland rms 23s or 28s-f show rms 25s or 28s-f show rms 25s or 28s-f show rms 25s or 28s-f show	10e. Street and Number  18724 Pie	Somery GAit r Point Pl	hersburg 101. Zip Code	879	10g. Citizen of V	Vhat Country?
or he mine	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Wes Decedent of His If Yes, specify Cuban	panic Origin? (Specify Ye, Mexican, Puerto Rican, o	1	e - American Indien, k, White, etc.
n 72 na na na na na na na na na na na na na n		ducation 16	6a. Decedent's Uauel Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working	16b. Kind of Bu	
d 2 should be flied the and Mental Hygis T la marked other traumatic event, T o Be Cc	BABOUCAR J	Allow		18. Mother's Name (First, Amie S	Middle, Maiden Sumam	9)
es 1 and 2 of Health e of Hem 27 la r other tra	19a. Informant's Name/Relationship  Ather  20a. Method of Disposition  1 Burial 2 Cremetion 3 I  4 Donation 5 Other (Speci	Removel from State	9b. Mailing Address (Street all 8724 Pier of Disposition (Name of Itery, crematory or other place	Point Pl	Faithersbu 20c. Location-	rs, md 20879 City or Town, State
permit. Peg Depertment Important: I any Injury o	21. Signature of Funeral Service Lice	nsee	22. Neme end Address			ine, mary und
Physician /Medical Examiner	23a. Pert1. Enter the disease, or con shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)		o not enter the mode of dying  Class vot a consequence in):			Approximate Intervel Between Onset end Death
entificate be associted ing physician and as the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	C	a consequence of):			
that the death certific ed by the ettending p detached for use as: Physician/Mex	Part II. Other significant conditions (	contributing to death but not resulting	g in the underlying cause give	n in Part I. 23	ib. Did tobacco usa cor	ntribute to the causa of death
requires these should be d				24	a. Was an autopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death?
ysician: The law is certificate has b director, page 2 a fro Be Comple	25. Was case referred to medical			20.51	1 □ Yes 2 □ 100	1 Yes 2 No
Physician: this certific ral director,	examiner?	Hospitel: 1 Inpatient 2 ER/	Outpatient 3 DOA Other	4 Nursing Home 5	□ Residence 6 □Oth	er (Specify)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thicompletely filled in by the funeral Medical Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined	(Month, Day Year)		es 2 No 281. Loc	escribe how injury occurr cation (Street and Numb y or Town, State)	er or Rural Route Number,
To the Hospital or within 24 hours at To the Funeral Di completely filled in Medical Cer	(Check only 2 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination	ge, deeth occurred at the time	e, date end place, and due	to the cause(s) and ma	nner as stated. and due to the cause(s)
To the Hospi within 24 hou To the Funer completely fill	29b. Signature and title of certifier  Humus	and manner stated.	29c. License	number	29d. Date signer	d (Month, Day, Year)
State	Sheri Hamers 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a)    e	a) (Type, Print) Medical Cent	er DR. Rock	Kville, md	,20850
Registrar	FEB 2 4 2000	Server B.	boarle			



tems 29c,29d,30 per ME7		Cen	ificate of	Dealli	2. Date of D	Reg. No.	2 3	Fime of Death		
n					Month	Day	Year			
CURTIS L. HARREI  4a Facility Neme (If not institution, give				4b. City, Town, o	DECEMB or Location of Dea			2:00pm		
PENINSULA REGION		TER		SALISBU	RY		COMICO			
5. Social Security Number 6. 5	Sex 7. Age (In yrs. la		If Under 1 Year Months Days		rs. 8. Date of B			Stete or Foreign		
246-84-8656	IXM 2□ F 48	Yrs.			2-20-		N.C.			
Usuel Residence of Decedent  10a. Stete 10b. County	10c. City	Town or Loca	ation				10d. In	side City Limits		
VA . N/A	NEW	PORT N	EWS				- 1	XYes 2□No		
10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?			
349 ST. THOMAS	DRIVE APT. 25B		23606			USA				
11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?		as Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		ce - American Ind ck, White, etc.	dien,		
1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Detes:	1[	☐Yes 2☐No	Specify:		Specif	BLACK			
15. Decedent's E	ducation	16a. Decede	nt's Usual Occup	pation	. 4 % .	16b. Kind of B	usiness/Industry			
(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	lite. Do	ind of work done O NOT use retire		vorking	EDIIG	TT ON			
		TEA	CHER	40.00		EDUCA				
17. Father's Neme (First, Middle, Last,					Tar Man		ne)			
JOHN T. HARRELL  19a. Informent's Neme/Reletionship (	Type, Print)	19b. Mailing	Address (Street		ICE MORR		State Zin Code	)		
JOYCE STEWART(S:					APT 1-C					
20a. Method of Disposition	20b. Pla	ace of Disposi	tion (Name of story or other ple	-	Date		- City or Town, S			
1 Burial 2 Cremetion 3 4 Donation 5 Other (Specific	Hemoval from State				12-29-9	9 WINDSO	OR. N.C.			
4 Donation 5 Other (Specify)  HILLCREST CEMETERY  12-29-99 WINDSOR,  21. Signature of Funerel Service Ucensee  22. Name and Address of Facility PHILLIPS FUNERAL HOM										
Joseth (	1. Hume				ST. BALT					
23a. Part1. Enter the disease, or com shock, or heart teilure. List only	plicetions thet caused the deeth. one cause on each line.	Do not enter	the mode of dyin	ng, such es card	iac or respiratory	errest,	Inter	roximate val Between et end Death		
Immediate Cause (Final	Dilite	1 C	adis	4	+1.					
disease or condition resulting in death)	a. Due to (or	as a consequ		JOY.	al no					
	h									
Sequentially list conditions, if any, leading to immediate	Due to (or	es a consequ	ence of):							
cause. Enter Underlying Cause (Disease or injury that initiated events	C									
resulting in death) Last	Due to (or	es a conseque	ence of):							
	d									
Pert It. Other algnificant conditions of	ontributing to death but not resul	ting in the und	lerlying cause giv	ven in Pert I.	23b. Did	i tobacco use co	ontribute to the	cause of death?		
					1	Yes 2□ No	3 Probably	Unknow		
					242 141-	e an arden	24h Wara a	itopsy findings		
						s an autopsy lormed?	available	prior to ion of cause		
					Acet	Vac allate	of death			
25. Wes case referred to medical				26. Place of F	Deeth (Check only	Yes 2 No	1 DYes	2□ No		
examiner?  Yes 2 No	Hospitel: 1   Inpatient 2	R/Outpatient	3 DOA Ott	2007	Home 5 Res		her (Specify)			
27. Manner of Death		28b. Time of Injury	28c. Inju	y at	28d. Describe	how injury occu	rred			
2   Xccident investigation			M 1	Yes 2 □ No						
3 ☐ Suicide 6 ☐ Could not be determined		ne, ferm, stree	et, fectory, office			(Street end Num own, Stete)	per or Rural Rou	te Number,		
29a. Certifier 1□ Certifying Ph	yalclan: To the best of my know	ledge death	occurred at the ti	me, date and nis	ce, and due to the	cause(s) and m	anner as stated			
internal control of the second	niner: On the besis of examinetic and manner steted.							cause(s)		
29b. Signature and title of certifier	0.0		29c. Licens	se number		29d. Date signe	ed (Month, Day,	Year)		
Ul ander	lew		0.0	.M.E.		January 2	1, 2000			
30. Name and address of person who	. ^				01003					
VI THEST LACKES	(N) 111 Penn S	treet, E	saltimore,	Maryland	21201					
31. Date filed (Month, Day, Year)	32. Registrer's Signet									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPhyG780 2/28/2000 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MARJORIE OWINGS December 22, 1999 10:25AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Funeral Days Hours Months 1 M 2 F 92 Director 526-32-2200 January 6, 1907 Maryland Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 830 West, 40th Street, 21211 USA Hema ? 11 Marital Statue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Departit. Pages 1 and 2 should be filled within 72 hours after control of Health and Mental Hygiene. Introducer: if Nem 27 is marked other than "natural, or her any Injury or other traumatic syam, the Medical Pages." Armed Forces?

1 Yes 2/2 No
If Yes, Give Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Medical Secretary Private Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Clara Virginia Bushey John Hammond Owings 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 East Baltimore Street Suite 901 Baltimore Maryland 21202 John B Hull Lawyer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State Reisterstown Meth Church Cem. 12/27/99 Reisterstown, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility nature of Funeral Serve Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the distance of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death Physician /Medical Immediate Cause (Final horns Pulmonam disease or condition resulting in death) Examiner Examine Venous Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. MITTIE Physician/Medical Due to (or as a consequence of): 2 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 20 No 1 ☐ Yas 2 ☐ No Vital 25. Wes case referred to medical examiner? 89 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation To the Hospins after death, within 24 hours after death. To the Funeral Director A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end dua to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) FEB28 2000

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

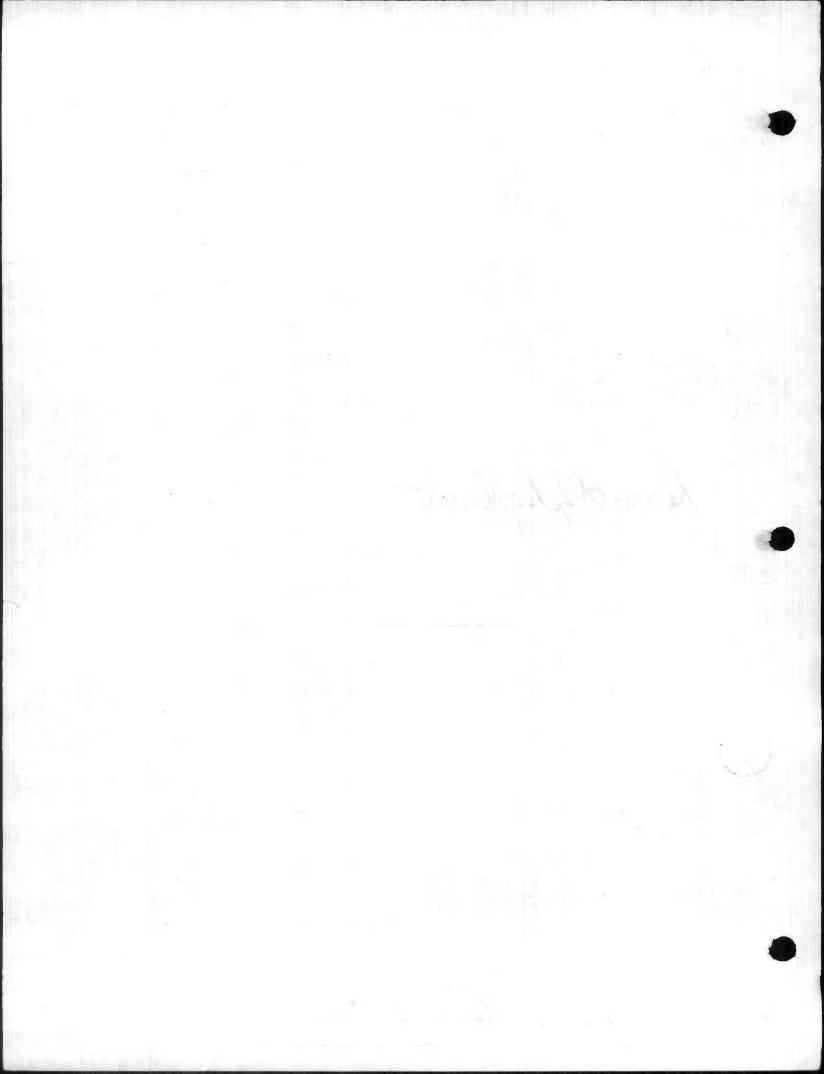


29c. License number

D37133

29d. Date signed (Month, Day, Year)

December 22, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** Alice L. Jamison 25,1999 July 3:30 AM /Medical 4e. Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Charles Hospice of Charles County
Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) LaPlata If Under 1 Year If Under 24 Hrs. 5. Sociei Sacurity Numbar 8. Data of Birth Month, Day, 9. Birthpiace (State or Foreign Country)
1908 North Carolina Funeral Hours 578-16-7153 1 □ M 2 ☑ F Months Days 91 Director Usuai Rasidanca oi Decedani 72 hours after death with the Maryland 10b. County 10a. Stata 10c. City. Town or Location 28a-f show 10d. Insida City Limits rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Charles Director Yas 2□No Waldorf 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 846 Copley Avenue 20602 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 14. Rece - American Indian. Biack, Whita, atc. 1 Yas 2 The 1 ☐ Nevar Married 2 ☐ Married 21215-0020 1 Yes 2N No Spacify: Specify: Black Completed by **%**Widowed 4 □ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "I Ity or other traumatic event, the Mes Eiamantary/Secondary (0-12) Coilege (1-4or 5+) Domestic Private 12th Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Willie Langford Margaret Kearney Langford 2 19a. Informant's Name/Rejetionship (Type, Print)
Sherita Thomas / Daughter 19b. Meiling Address (Strael end Number or Rural Routa Number, City or Town, State, Zip Code) 846 Copley Avenue; Waldorf, MD 20602 20b. Placa of Disposition (Nama of cemetery, crametory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Buriel 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) permit. Page Department of Important: If any Injury or once. Lincoln Cemetery 7/31/99 Brentwood, MD 21. Signajura of Funeral Service Licenses 22. Nama and Addrass of Facility Latney's Funeral Home CCO348 3831 Georgia Ave NW; Wash., DC 20011 non 234 Part I. Entar tha disaase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart feilure. List only one cause on each line. Approximata Intarval Batween Onset end Deeth **Physician** METASTATE OVARIAN CANCER /Medical Immediate Cause (Finel disaasa or condition rasulting in daath) Examiner Examiner The law requires that the deeth certificate be executed burial-transit Saquantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in death) Lest and physician Box 68760. Physician/Medical Dua to (or as a consaquanca of): hed for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? hes 1 ☐ Yas 2 No this certificate 1 ☐ Yas 2 ☐ No or Attending Physician: effer death. Director: After this certifica director, Be 25. Was casa raiarrad to medical axaminer? 26. Pieca of Death (Check only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To funeral 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b Time of 28c. Injury et Work? 5 Pending Invastigation 1 Neturel 2 Accidant 1 ☐ Yas 2 ☐ No the 6 Could not be determined 3 Sulcida 28a. Placa of Injury - At home, ferm, straat, factory, offica building, etc. (Specify) Location (Straet end Number or Rurel Routa Number, City or Town, Steta) filled in by 4 Homicida To the Hospital of within 24 hours of To the Funeral D completely filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and mennar as steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and menner stated. Medical 29a Certifier 29b. 5ign 29c. Licansa number 29d. Data signed (Month, Day, Yeer)

I MAGNOLIA DRIVE - LAPIATA DRIVE MO 2064

State Registrar 30. Nema and address of person who complated causa of death (Item 23e) (Type, Print)

H. WAT

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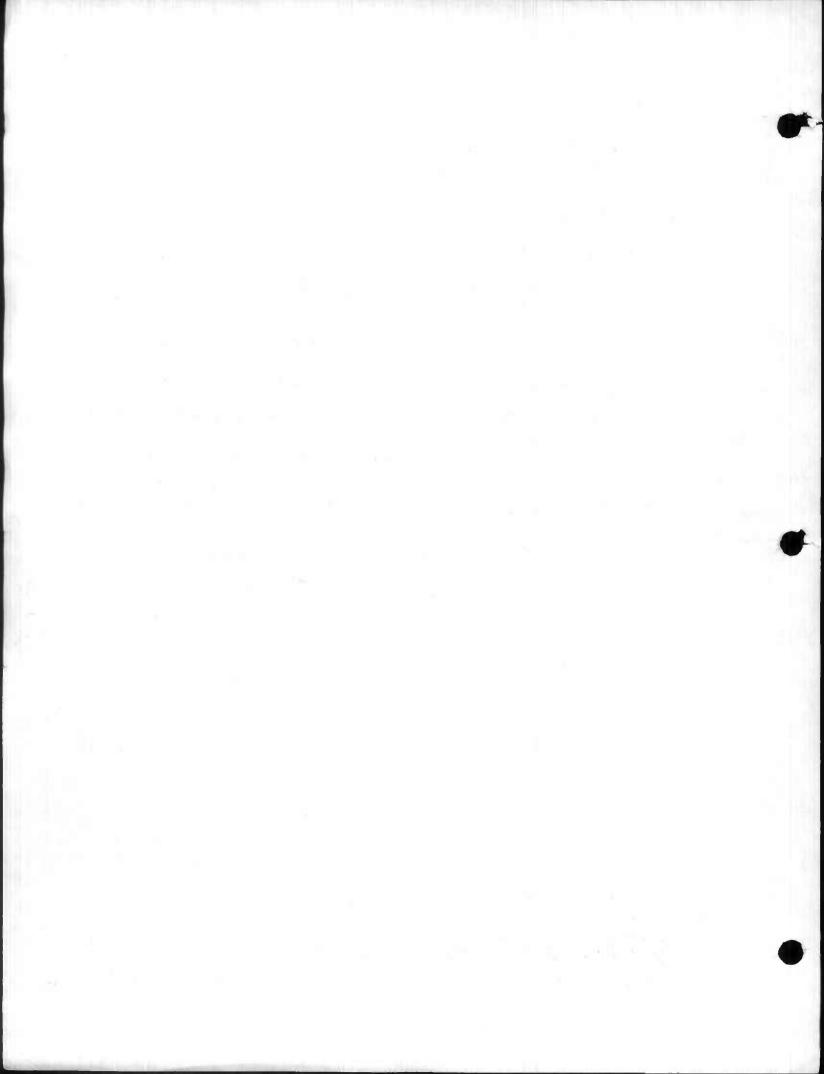
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#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death YOUT **Physician** 1999 450 PM AMELA ANN RAINS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 304 S. CAMDEM FRUITLAND WICOMICO AVE Hours Min. 8. Dete of Birth Moath, Day Year 5 5 Social Security Number 214-68-5685 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days 1 M 200 44 Yrs. MONTO! Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Xas 2 No MD Wicomico FRUITLAND Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 304 S. CAMDEN AVE 21826 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 D No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiens. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 Yes 20 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UPHOLSTERL CUSTOM AUTO UPHOISTERY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ENN RUARK SADIE HANNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3045 CAMDEN AVE FRUTUAND ND 21824 J. R. RAINS HUSBAND 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 12-16-99 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State SAUSBURY, MD SALKBURY CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility WERAL HOME 21. Signature of Funeral Service Licensee stern posicking MO0416 BOX 6 BIXALVE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Adenocucinos of Lung Immediate Cause (Finel Metes totic disease or condition resulting in death) Examiner physicien end s the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. NOTES 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate 1 Yes 2 \$400 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours effer deeth. To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 296. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar Va

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

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Feb. 22 2000

145 E. Gradi St. Jelisbury MD.

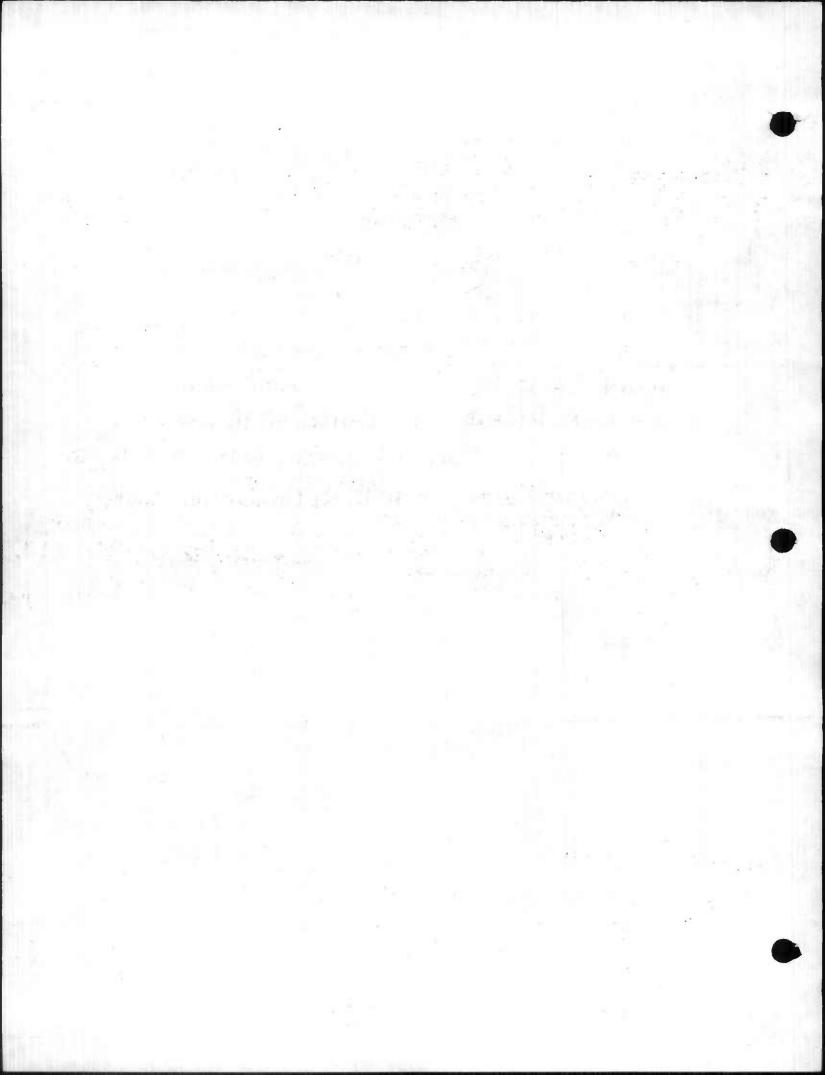
m.o

M, J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mantin

32. Registrar's Signature



DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit, Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician, once. notified at the medical examiner must be and completely filled in by the burial, cremation, or removal. other traumatic event, HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed the attending physician a 0 Injury. TO THE FUNERAL DIRECTOR After this certificate has been signed by it fied within 72 hours after death with the State Dept, of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any In THE DAY 223

29b. SIGNATURE AND TITLE OF CERTIFIES

St. DATE FILED (Month, Day, Year)
MAR 0 9 2000

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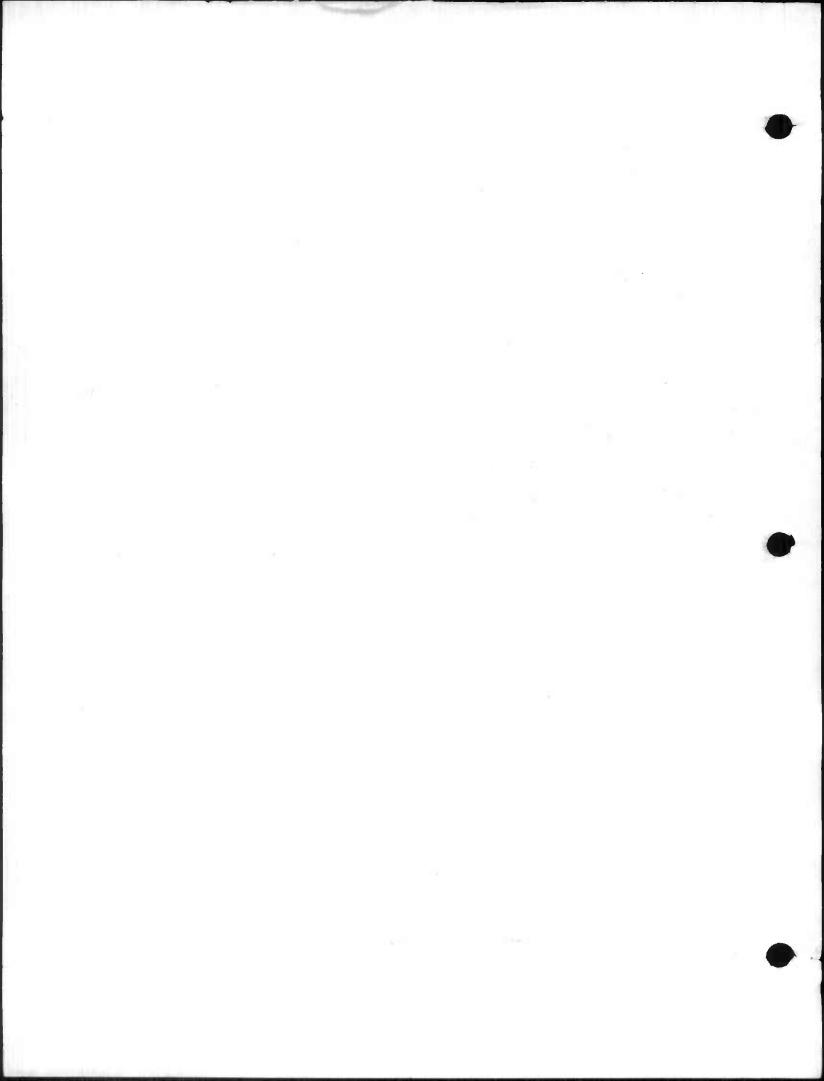
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42879 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 0 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State t - M 2 X F 9b. CLTY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR tor RESIDENCE OF DECEDENT top COUNTY 10s. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 WES 2 NO ano FUNERAL 10e. STREET AND NUMB 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? race 1t. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-- American Indian, White, etc. t Never Married 2 Married If yes, specify Cuban, Mexican, Puarto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: ВУ Specify Black 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Robert Parrott Donna Watson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 3605 Parkway Terrace Dr #3, Suitland, MD Donna Watson/Mother 20746 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Buriel 2 Cremetion 3 Removal from State
4 X Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSER Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Miller Baltimore, MD 21201 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death IMMÈDIATE CAUSE (Final disease or condition resulting in death) DEVERE Prematurity
DUE TO (OR AS A CONSEQUENCE OF): Severe CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 | YES 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Delta \text{UNCERTAIN } \( \Boxed{1}\) PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: npetient 2 ER/Outpetient 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER
//Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 \_ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner ee stated,

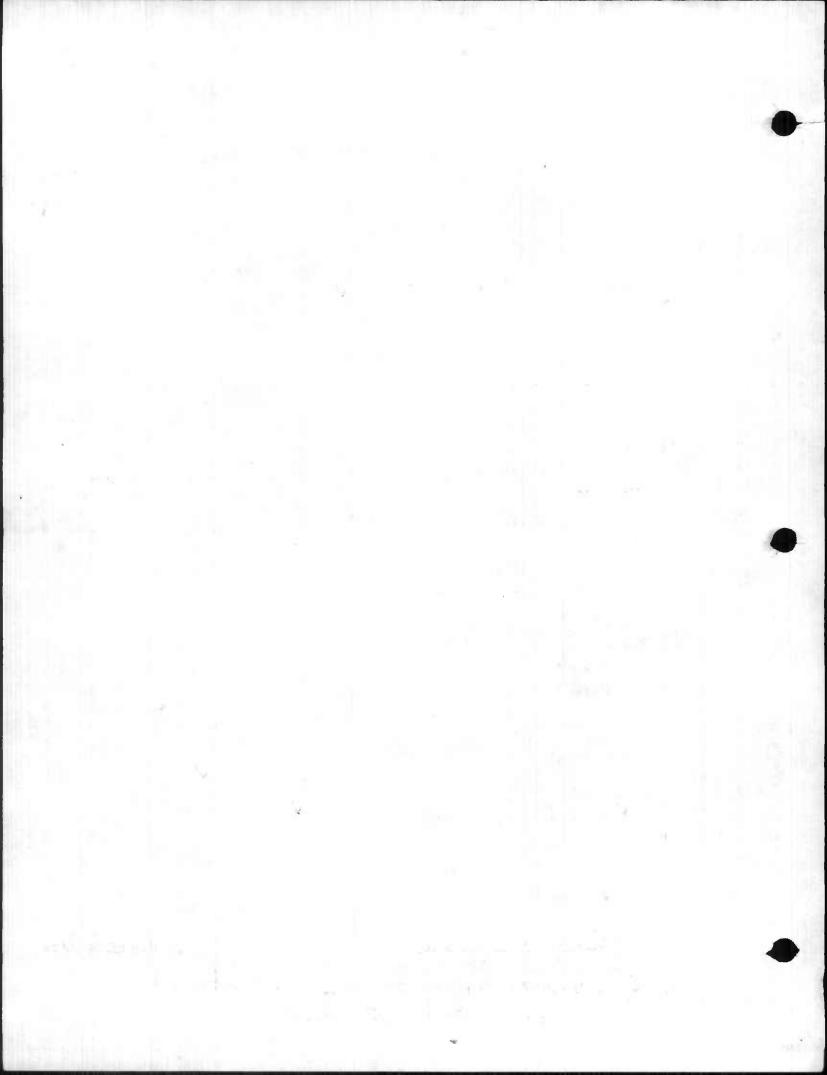
29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) 200 970 99 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) 2. REGISTRAR'S SIGNATURE



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

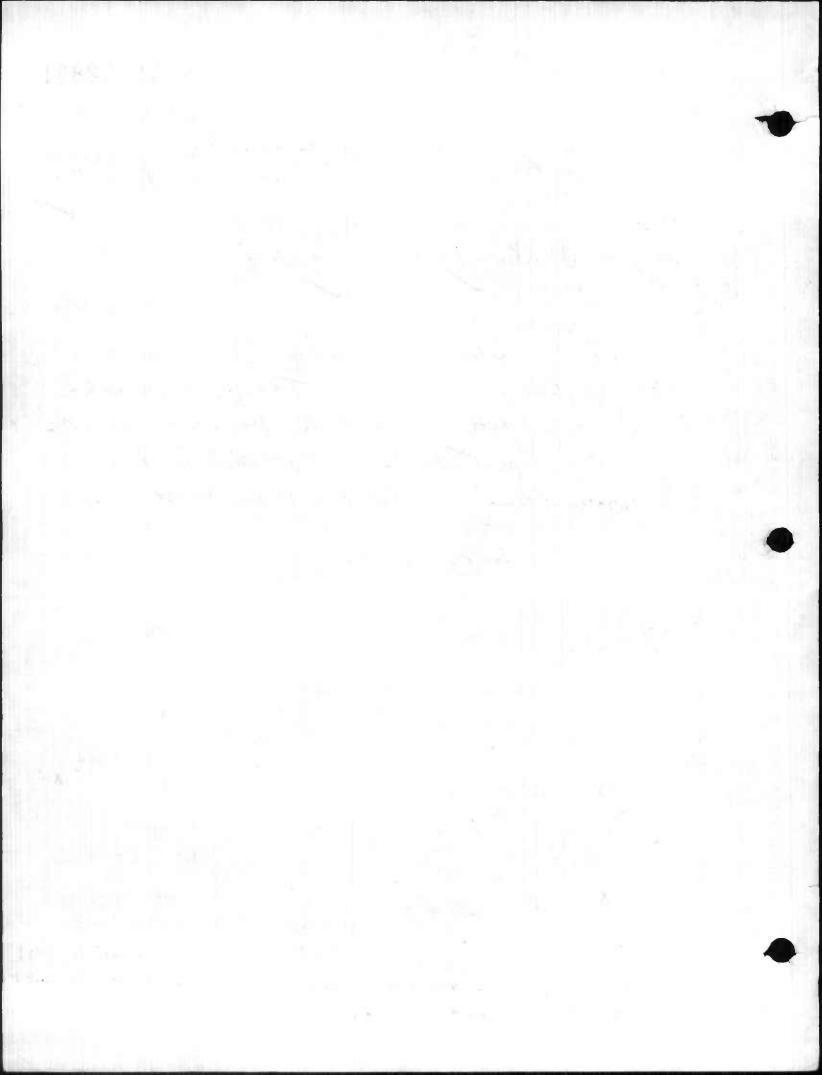
State of Maryland / Department of Health and Mental Hygien 9 4 2 8 8 0

					Certificate of	Death	R	eg. No.	4 6	000
	Bloodsta	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
£	Physician /Medical	Ernest C. Murra	ау				6		99	9:40am
	Examiner	4a Facility Name (If not institution, give stre	et and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
		Mariner Health				Clintor				eorge
	Funeral Director	5. Social Security Number  246-03-6006  Usual Residence of Decedent	2□ F 7. Age (In y		nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		910	9. Birthp Coun	N.C.
	Maryland H ahow Ted at	10a. State 10b. County			or Location estville			. 4	1	0d. Inside City Limits 1 ☐ Yes 2 1 No
	ter death with the Marylan free must be notified at Funeral Director		venue		10f. Zip Code 2074	17	1	0g. Citizen of V		try?
21215-0020	by DV	3 M Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces? 1 Yes 2 W No If Yes, Give Year or Dates:	U,S.	13. Wes Decedent of If Yes, specify Cul		Specify Yes or No- to Rican, etc.)	Blec	e - Americ k, White, Bla	etc.
5-0	natural',	15. Decedent's Educati (Specify only highest grade of		16a. I	Decedent's Usual Occu Give kind of work done	pation during most of wo	rkina	16b. Kind of Bu	siness/Inc	dustry
121		Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retin	ed)				
2					Enigneer					rnment
and	A S P & M	17. Father's Name (First, Middle, Last)	Manager				me (First, Middle, I ilable/(		0)	
Z	should be marked of umartic eve			401					Ctota 7:	Codel
e, Maryland	25.0	19a. Informant's Name/Relationship (Type, Ernest C. Murra	y Jr.	1	Meiling Address (Street 904 Altar	nont Ave	enue Foi	crestv	ille	, MD.
Baltlmore,	6 - E	20a. Method of Disposition  1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	Over from State		Disposition (Name of crematory or other plants of the complex of t		6/17/99	20c. Location -	1	
Ball	permit. Pege Department of Important: If any Injury or price.	21. Signature of Funeral Service Licensee William Latney per	DVR		22. Name and Addr Georgia	1	-			me 3831 D.C.
ķ.		23a. Part1. Enter the disease, or complicat shock, or heart feilure. List only one of	ions that caused the de ause on each line.	eath. Do no	ot enter the mode of dy	ing, such as cardia	c or respiratory em	est,	1	Approximete Interval Between
	Physician									Onset end Deeth
	/Medical Examiner	Immediate Cause (Finel disease or condition	Old Card	liova	scular A	ccident				5 years
п		resulting in death)	Due to	o (or es a co	onsequence of):				l	
	Paris Paris	b	Hyperter	sive	, Corona	ry Arte	ry Disea	ase		10 years
,09	rificate be executed ag physician end es the burlal-tranait	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to	O (Or es a co	onsequence of):					
ox 68760,	E 00	resulting in death) Last	Due to	(or es a co	ensequence of):				-	
Box	e attendin of for use	Part II. Other significant conditions contrib	uting to doubt but not r	naudina in	the resident increase of	ives in Badd	22h Dida		needburen er	the cause of death?
P.0	the soft	Part II. Other significant conditions contrib	uting to death but not i	esumy m	the underlying cause g	ven in Pelt I.	1 □ Y	. /		bably 4 Unknown
	to se d									
Records,	peed shou						24a. Wes a perfor	n autopsy med?	av	are autopsy tindings allable prior to mpletion of cause death?
	The law atta has pege 2						1 Y	es 2 No	1[	Yes 2□ No
Vital	certificata rector, peg	25. Was case referred to medical				26. Place of De	ath (Check only or	ne)		
<b>1</b>	2 00	examiner? 1 Yes 2 No Hos	oital:	☐ ER/Out	patient 3 DOA	ther: 4 Nursing I	Home 5 ☐ Resid	ence 6 Oth	er (Specil	y)
lon of	Attending Physical death.  Setor: After this by the funeral digital distribution of the filter of the following th	27. Manner of Death 1 (Britatural 5   Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Ti	jury W	iry at ork? ] Yes 2 □ No	28d. Describe h	ow injury occum	ed	
Division	tal or Attending P no effer death. et Director: After ti led in by the funera Certification:	all cuistes Cl Could not be -	28e. Place of Injury - A building, etc. (Spe	t home, fen	m, street, factory, office		28f. Location (S City or Town		er or Rura	Il Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physical Examiner one)	n: To the best of my k On the basis of exami	nowledge, ination and	death occurred at the t for investigation, in my	ime, date and place opinion, deeth occ	e, and due to the c urred et the time, d	ause(s) and ma ate end place,	nner as s	tated. o the cause(s)
	within To the comple	29b. Signature and fitte of certifier			29c. Licer	se number	2	9d. Date signe		
	F>F0	Physis h	Calca	ano	74	540		6 m	ARC	H 2000
		30. Name and address of person who comp	leted cause of death (I	tem 23a) (1			linton		,	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature	La La	0.110	MOVIM	11/01	13-0	7 - 04
	Registrar	MAR 0 9	ZUUUP /32	per-	1. P	outs				



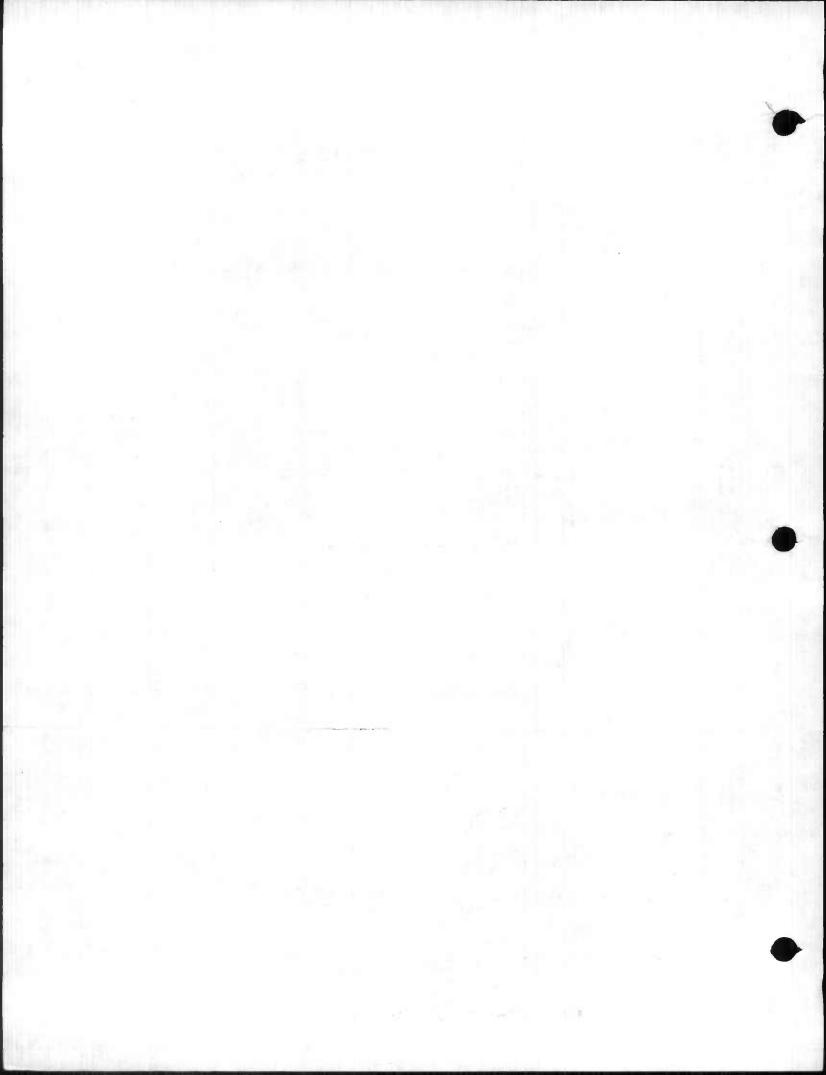
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	G781 3-10-2	2000 JAB	· Certino	cate of Death	0.000	Reg. No. 99	42881
1. Decedent's Nama (Fi	BOY DEMME	KE			2. Deta of Do	Day Day	Year S: 15
4e Fscility Name (If not			11	4b City, Town,	or Location of Deal	th 4c. County or	f Death
THE JOH	HNS /	TOPKINS	HOSPITA	72 BALTIME	WE CIT	7	
5. Social Security Numb	Wn 100	7. Age (In)			Irs. 8. Data of Bi	by. Year)	9. Birthplace (State or For Country)
Usual Rasidence of Dec 10a. Stata 10	b. County	10c.	. City, Town or Location	1			10d. Inside City Lie
a mD		Si	ilver Spi	ing, m	D		1 1 es 2
10e. Street and Number	or. 1	VI	10	I. Zip Code	/	10g. Citizen of Wh	net Country?
= d00 -	-1010h	2. Was Deceden Every	eigh	2090 Decedent of Hispanic Origin?	(Specify Vac or N	U S	- American Indian,
11. Marital Status		Armed Forces? 1 ☐ Yes 2 ₽ No	if Yes,	specify Cuban Mexican, Pu	erto Rican, etc.)	Bleck	, White, etc.
3 Widowed 4	Divorced	If Yes, Giva Yaar or Datas:	1 U Y	es 2 No Specify:		Specify:	Black
15. (Specify of Elementery/Secondar	. Decedent's Educationly highast grada	ation co <i>mpleted)</i>	(Give kind o	Usual Occupation of work done during most of the option of	working	16b. Kind of Bus	iness/Industry
Elementery/Secondar	ry (0-12)	College (1-4or 5+)	me. DO No	N/n		N,	14
17. Father's Name (First	st, Middle, Last)	11:	1	18. Mother's N	leme (First, Middle	Maiden Sumeme	)
2 A Fewor	rK, ES	Kinder	-	13	ega	Dem	
19a. Informent's Neme/	1.	1. 11	- 2001	dress (Street and Number or	Rural Route Numb	per, City or Town, S	acia has
1909a De	mneke	/ mother	b. Plece of Disposition	(Neme of	Date	20c. Location - C	city or Town, Slete
1 Burial 2 Cr 4 Donetion 5		6 1	cemetery, cremetory	Vib Tosh	12/1/99	BaH:	mac my
21. Signeture of Funere		115 posq 1 2	22. Nen	ne end Address of Facility	1,10/1/1	109/11	incle, III
1 Dela	orap. E.	Vans	5H1	4-600 n.	WOLFE	St.	2/287
23a. Pert1. Entar tha di shock, or heart fail	lisaese, or complications. List only one	etions thet caused the deceuse on each line.	feeth. Do not enter the	mode of dying, such es card	liac or respiretory		Approximete toterval Between
Immediate Cause (Fine	ol lo						Onset end Deati
Immediete Cause (Fine diseese or condition resulting in deeth)	el a.	Severe	Prema	turity			Z hour:
disease or condition resulting in death)	el a.	Severe	Prema to (or es a consequence	tenty			
disease or condition resulting in deeth)	a.		Prema to (or es a consequence				
disease or condition resulting in deeth)  Sequentially list condition if any, teading to immediate the cause Enter Underlying	a. b. diete	Due to	o (or as e consequence	of):			
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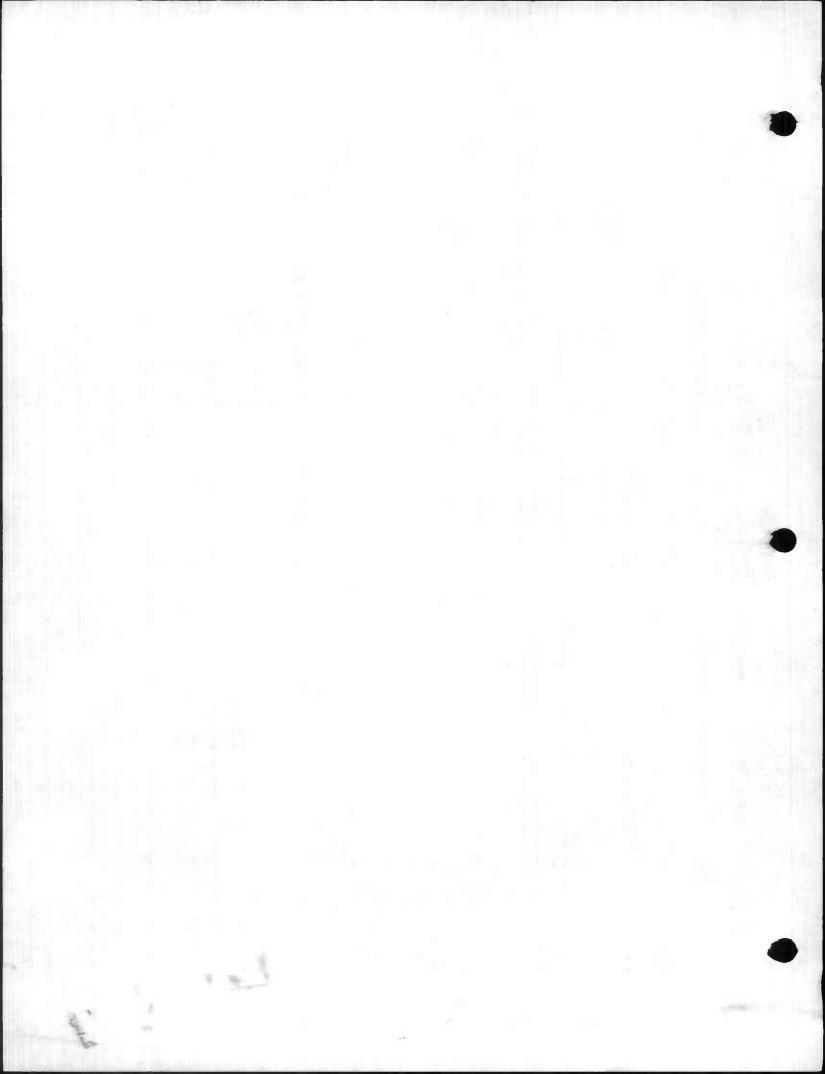
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Marylar		rtment of F			Reg. No.	99 1,281	82
Physician /Medical	1. Decedent's Nama (First, Middle, La MANASSES	ANDR	EWS			2. Data of De Month ECEMBEI	R 1, 199		
Examiner	4a Facility Name (If not institution, giv SAINT JOSEPH ME	,			4b. City, Town, or L TOWSON		,	of Death IMORE	
Funeral Director		ex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Yaar Months Days	Hours Min.	8. Dala of Bir (Month, Da DEC 1	ly, Year)	Birthplace (State or I Country)     MARYLAND	Foreign
Mand	Usual Rasidence of Decedent  10a. Stata 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City	Limits
Many Mary Mary Ctor	MARYLAND BALTIM	ORE BA	ALTIMOR	E		_ 22		t X Yas 2	2□No
with the or 24	10e. Street and Number 2414 PRESTON STR	ттт		10f. Zip Code 21213			10g. Citizen of V	The state of the s	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow and highly or other traumatic event, the Medical Emirine must be notified at ance.  To Be Completed by Funeral Director	11. Marital Status 1 ☑ Nevar Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	11	/as Decedent of F Yas, specify Cub	dispanto Origin? (Span, Maxican, Puarto	pecify Yas or No	Blac	e - American Indian, ck, Whita, atc.	
ours and d by	3 Widowed 4 Divorced	If Yas, Giva Year or Dates:		□ Yas 2X No	Specify:		Specify	DULION	
21215-0020 ed within 72 hours af ygiene. or than "natural", or t, the Vedical Examp Completed by F	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of work	king	16b, Kind of Bu	O O	
and 2 be filed dother avent, the	17. Fathar's Nama (First, Middle, Last)				18. Mothar's Nam	a (First, Middle	, Maiden Suman	-	
Maryland d 2 should be flie th and Mental Hy 7 is marked othe traumatic avent To Be (	UNKNOWN				ROSALAND				
and 2 sh satth and n 27 la m	19a. Informant's Name/Ralationship ( ROSALAND TAYLOR	Type, Print) (MOTHER)			STREET, B				
Baltimore, Nomit. Pages 1 and Department of Health Important: If Item 27 my injury or other trades.	20a. Mathod of Disposition  1	Removal from State	Place of Dispos	ition (Name of atory or other pla	ce)	Data /13/00	20c. Location -	City or Town, Stata  ORE, MARYLAN	ND
Baltim permit. Pag Department Important: h any injury o	21. Signature of Europe Service Licer	1500	22.	Nama and Addra		an.			
D 89558	23a Parti. Entar the disease, or com shock, or heart failure. List only	2,	76	001 OSLE	H MEDICAL R DRIVE,	TOWSON,	MARYLAN	ND 21204	
Physician /Medical Examiner	Immediata Causa (Final disaasa or condition resulting in death)	PREMATURE RU	JPTURED or as a consequ		ES				
orou, sate be assected hysician and the burlat-transit dical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enlar Underlying Cause (Disease or injury that initiated events	Dua to (	or as a consequ	ence of):					
D 5 5 2 2	that initiated events rasulting in death) Last	Dua to (	or as a consequ	ence of):					
at the death certified by the attending etached for use a Physiciary	Part II. Other significant conditions o	ontributing to death but not rai	sulting in the un	derlying causa gi	ven in Part I.	23b. Dld	tobacco use co	ntribute to the cause of	death?
by Bank the St.	CHORIOAMNIONITUS					10	Yes 2 No	3 □ Probably 4 💢 U	nknow
Pole 2 ss Pole						24a. Was parte	an autopsy ormed?	24b. Were autopsy fin- available prior to completion of cau of death?	
	25. Was casa rafarred to medical						Yas 2 No	1 □ Yes 28€N	lo
Physician: Thysician: This certificate ral director, per TO Be Co	axaminer?	Hospital: 1 Anpatient 2	ER/Outpatient	3□ DOA Ott	26. Placa of Dea her: 4□ Nursing H		on <i>e)</i> idence 6 □Oth	er (Specify)	
After this funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo			how injury occur		
Para in	3 Suicide 6 Could not be detarmined	28a. Place of Injury - At h building, etc. (Speci	noma, farm, si <i>re</i> ify)	et, factory, office		28f. Location ( City or To	(Street and Numb wn, State)	er or Rural Routa Numbe	er,
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of axamina and manner stated.	owledge, death ation and/or Inve	occurred at the tiestigation, in my o	ma, data and place, opinion, daath occur	and dua to tha red at tha tima,	cause(s) and ma data and place,	nner as stated. and due to tha cause(s)	
within 2 To the comple	29b. Signature and title of certifier	A _ /		29c. Licens			29d. Data signe	d (Month, Day, Year)	
	Seven MC	U A		D	22092		12/	14/99	
	30. Nama and addrass of person who of STEVEN BERLIN, M.				CKEYSVILLI	E, MD.	21030		
State Registrar	31. Data filed (Mönth, Day, Year)	32. Registrar's Sign		back)					



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Decedent's Neme (Fire	st. Middle I aet			Cei	runcat	e or	Death	2. Date of De	Reg. No.		2883	
								Month	Day	Year		
4- Facility Name (Mant)	vner	treat and numb	arl				4b. City, Town, or	December			10:30 ar	1_
4701 Willa			er)				Charry (	baca	Mont	t a a m a s	ry	
5. Social Security Number			Age (In yrs	last birthday)	If Under		If Under 24 Hrs	8. Dete of Bir	rth	9. Birthple	ace (Stata or Forei	gn
223-52-542		M 2 F	84	Yrs.	Months	Days	Hours Min.	Dec.	th year) 24, 191	5 Per	nnsylvani	.a
Usual Residence of Deci	. County		10c. C	ity, Town or Lo	ocation						d. Inside City Limit	S
MD M	ontgomer	у		Chevy	Chas	se					↑ Yes 2□N	0
MD M  10e. Street and Number					10f. Zip	Code			10g. Citizen of V	What Count	ry?	
4701 Willa  11. Marital Stetus  1 Never Married	rd Avenu	ie #718			20	815			USA			
11. Marital Stetus  1 Never Married  3 Widowed 4 I	Merried	2. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	es? K∭No	1	Wes Deced If Yes, spe- 1  Yes		lispanic Origin? (5 an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Specify	e - America ck, Whita, e	tc.	
15. [	Decedent's Educ	ation		16a. Dece	dent's Usu	el Occup	ation		16b. Kind of Br	usiness/Ind	ustry	
(Specify on Elementary/Secondary 1.2	lly highest grade (0-12)	College (1-4	or 5+)		kind of wo DO NOT us omema		during most of wo	rking	Own I	Home		
	Middle, Last)					1	18. Mother's Na	ma (First, Middle	, Maiden Suman			
Rabbi Samu	el Waing	ger					Leah A	Allen				
19e. Informent's Name/F	Raletionship (Typ	e, Print)		19b. Maili	ng Address	(Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)	
Emanuel Y	avner -	Husban	d	470	1 Wil	lar	d Avenue	#718 Ch	evy Chas	se, MI	20815	
20a. Method of Disposition		C1		Place of Dispo cemetery, cree	natory or c	ne of other place	ce)	Data	20c. Location -	City or Tov	vn, State	
MXBurial 2 ☐ Cre 4 ☐ Donation 5 ☐		movel from St		rest L	awn (	Cemet	tery	1/2/00	Norfo	lk, Vi	irginia	
21. Signeture of Funerel	Service License	9		0 22	Name an Metro	od Addre	ss of Fecility Ltan Func	eral Ser	vice, In	nc.		
Julen	- Lill	2000	Ulk	7			Street			irgini	La 22310	
23a Pert1. Enter tha dis shock, or heart taill	easé, of complic ure. List only on	ations thet cau cause on aac	sed the dee h line.	th. Do not ent	er the mod	le of dyir	ng, such es cardia	c or respiretory e	errest,	# 1	Approximate Intervel Between Onset and Deeth	
Immedieta Cause (Final disease or condition resulting in death)	a.		Respi	atory	Distr	ess					6 Months	
				oras a consec Cancer	quence of):						6 Years	
Sequentially list condition if any, leading to immedicause. Enter Underlying	ns. b.			or as a consec	quence of):							
Sequentially list condition if any, leading to immedicause. Enter Underlying												
Cause (Disease or injury that initiated events resulting in death) Last	С.		Due to (	or as e conseq	juence of):					1		
Part II. Other significant Chronic	d.	Lat										
	- 0.									Î		
Part II. Other significant		_			nderlying o	ause giv	ren in Pert I.				the cause of deat	
Chronic	obstruct	.rve Lu	ng D19	sease				10	Yas 2□ No	3 Prob	ebly 4 ☐ Unkno	wn
									an autopsy	24b. We	re autopsy tindings ilable prior to	;
								pen	omeur	con	npletion of cause leath?	
								10	Yes 2 No	10	Yes 2 No	
25. Wes case refarred to axaminer?								ath (Check only	one)			
1 ☐ Yas 2 ☐ No	H	ospital: 1 🗆 Inp		ER/Outpatier	-	_	4 🗆 I Vulsing I	7.	idence 6 Oth		)	
100000000000000000000000000000000000000	Pending	28a. Date of (Month,	njury Day Year)	28b. Tima of Injury		28c. Injur Wor		28d. Describe	how injury occur	red		
2 Accident 3 Suicide 6 C	investigation Could not be detarmined	28e. Place of building	Injury - At h	oma, farm, str fy)	M reet, factor		Yes 2 □ No		(Street and Numb wn, State)	per or Rural	Route Number,	
29a. Certifier 1 (Check only one)	Certifying Physi Medical Examin	cian: To the be er: On the basi and manne	s of examina	owledge, death ation and/or in	n occurred vestigation	et the tir	na, date and place pinion, daath occ	e, and due to tha urred at the tima,	cause(s) and madata and place,	annar as str and due to	ated. the cause(s)	
29a. Certifier 1 (Check only 2 1 1 2 1 2 2 1 2 2 1 2 2 2 1 2 2 2 2	Portifier		2		290	c. Licens	e number		29d. Date signe	d (Month, E	Day, Year)	
1	, N	1/8		10		D35	5996		March	17, 2	2000	
30. Nama end addrass of	person who con	nploted cause	of death (Ite	m 23a) (Type.	Print)							
	Burell,					Driv	ve Silve	Spring	, MD			
31. Date filed (Month, Da	w Money "	00 D	istrar's Sign	-4		-						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Baby Girl Jones 1999 December 3, 1:00 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F Yrs Director 40 December 2,1999 Maryland N/A Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Directo ma 23a or 28a-f : must be notified Maryland Baltimore 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Lexham Court 21244 Funeral USA Berns 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give 8 altimore, Maryland 21215-0020 Specify: Black 1 Yas 2 No Specify: ğ 3 Widowed 4 Divorced Year or Datea: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Davon C. Harris Katrina R. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . nt of Health a If Item 27 is or other tra Katrina R. Jones - Mother 7402 Lexham Court Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State tery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 □ Donation 5 🖺 Other (Specify) Hospital 12-6-4 Sinai Hospital Baltimore, Maryland 21. Signatura of Funeral Service Licensee Disposal 22. Name and Address of Facility Sinai Hospital PATH 2401 W. Belvedere Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21215 Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Extreme prematurity Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): USB BS P.O. | 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 XNo 3 Probably 4 Unknown Records, Q page 2 should 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No certificate of Vitai Attending Physician: director, 25. Was casa referred to medicel Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1X Inpatient 2□ ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 No death. investigation 2 Accident N/A N/A N/A To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide N/A 29a, Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature ap title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
MAR 3 0 2000

Omotosho, M.D.

30. Nama

Sinai Hospital 2401 W. Belvedere Ave

32. Registrara Signature

9. Sparks

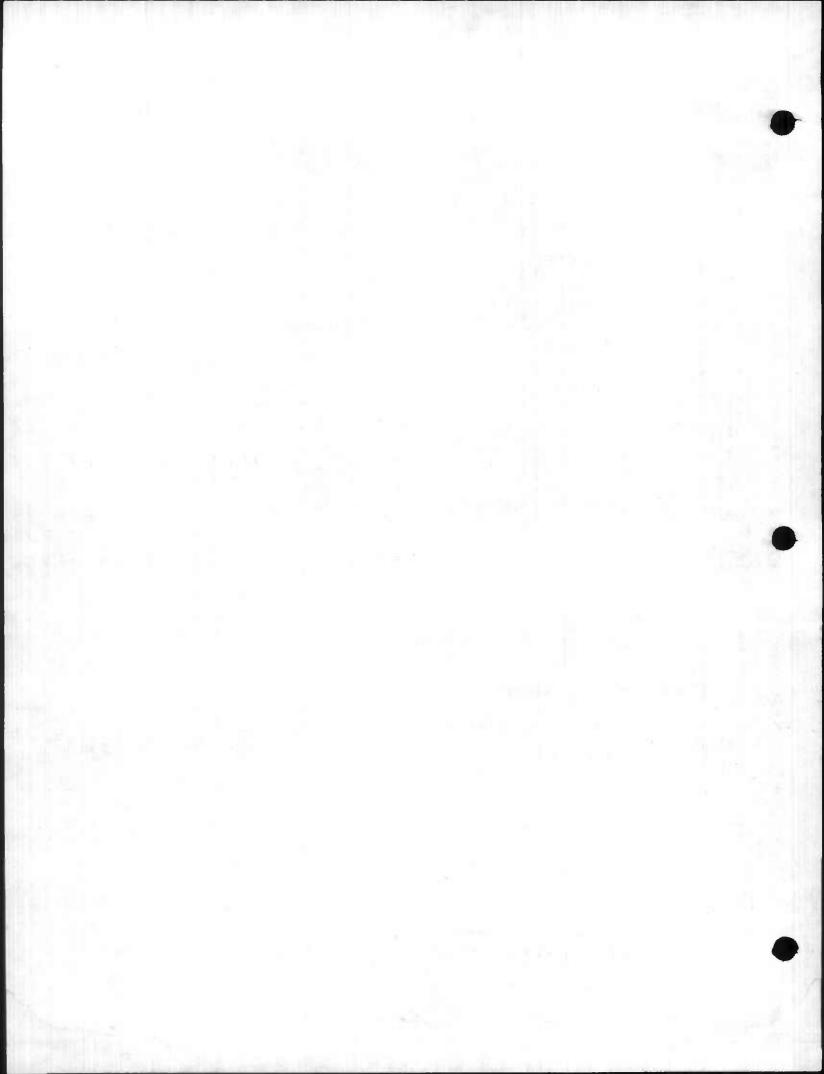
nd addrass of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

**RES000** 

December 3, 1999

Baltimore, MD 21215



Physici /Medic Examir

Funeral Director

permit. Pages 1 and 2 should be litted within 72 hours after death with the Maryland Department of Health and Mental Hygiene, important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ended.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

	State of Mary		epartment Certificate			and M		ene . 3. No.Q Q	1 1.	2005
1. Decedent's Name (First, Middle, Last)	)						2. Date of Death		- 4	3. Time of Death
UNKNOWN	(99-277)						NOVEMBER	Day 16.19	Year 999	8:30P.M.
4a Facility Neme (If not institution, give	street and number)			4	b. City, To	wn, or Li	ocation of Death	4c. County		1
SHOCK TRAUMA CENT	ER				BALT	'IMOI	RE		N	I/A
5. Social Security Number 6. Security Number 12	7. Age (In	yrs. last birth	hday) If Under Months	1 Year Days	If Under: Hours	24 Hra. Min.	8. Date of Birth (Month, Dey, 1 UNKNOWN	rear)	9. Birth unkn	place (State or Foreign (State)
Usuel Residence of Decedent										
10a. State 10b. County	100	c. City, Town	or Location							10d. Inside City Limit
unknown unknown	ı	1	unknown							unkhown²□N
10e. Street and Number	-		10f. Zip	Code			10	g. Citizen of	What Co	intry?
unknown				ι	ınkno	wn		un	know	n
11. Marital Status unknown	12. Was Decedent Ever	in U,S.	13. Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			ican Indian,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		7. 10. 10. 10. 10. 1			, Puerto	Hican, etc.)		ck, White	, etc. ack
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: U1	nknown	1 ☐ Yes 2	2 X No	Specify:			Specif	y: DI	ack
15. Decedent's Edu		16a. I	Decedent's Usua	i Occupa	ation		10	8b. Kind of B	usinass/l	ndustry
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of wor life, DO NOT us	rk done d se retired	unng mosi )	or work	ing			
unknown	unknown		unk	nown				ι	ınkno	own
7. Father's Name (First, Middle, Last)					18. Mothe	r's Nem	e (First, Middle, Mi	aiden Sumar	пө)	
unknown					u	nkno	own			
19a. Informant's Name/Reletionship (Ty.) $\cdot$ C $\cdot$ M $\cdot$ E $\cdot$	rpe, Print)						imore, MD			ip Code)
Oa. Method of Disposition  1 □ Burlal 2 □ Cremetion 3 □ R  4 □ Donetion 5 ☒ Other (Specify)	lemoval from Stete	0b. Place of cemetery	Disposition (Nerr r, crametory or of	ne of ther plec	в)	1	Date 2	Oc. Location	- City or 1	Town, State
1. Segrature of Euneral Service Licenses RODALO S.		tor			e, MD		rd 655 W	. Balt	imor	e Street
mmediete Causa (Final disease or condition resulting in death)	MULTIPL	_	JRIES							Interval Between Onset and Death
	000	10 (01 43 4 01	orisoquerios orj.						1	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due	to (or es a co	onsequence of):						1	
that initiated events resulting in death) Last	Due	to (or as a co	onsequence of):						1	
									1	
Pert II. Other aignificant conditions con	ntributing to death but no	t resulting in	the underlying or	euse giv	en in Part t			2 No		to the cause of deat obably 4 Unkno
				,			24e. Wes an perform	autopsy ed?	8	Vere autopsy finding vailabla prior to completion of cause of death?
							1 Yes	2 No	1	☐Yes 2☐ No
5. Was case referred to medical					26. Place	ot Deal	h (Check only one	)		
axaminer? 1 ☑ Yes 2 ☐ No	lospital:	3/2 ER/Out	patient 3 DO	Oth	ar:		ome 5 Residen		her (Spec	eify)
7. Manner of Death	28a. Date of Injury	28b. Ti		8c. Injun		yric	28d. Describe hov			,/
1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year) 11–16–99		jury 2 PM <sup>M</sup>		∢? Yes 2√⊊y	No	HIT BY T	TRATN		
3 Sulcide 4 Homlcide  Stockholder  Stockhold	28e. Place of Injury - building, etc. (S)	At home fer	m, street, factory				28f. Location (Stree City or Town, OREMS & (	et end Num Stete)		
9a. Certifler (Check only one)  1 Certifying Phys 2 Medical Examir	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge,	death occurred a	at the tim , in my of	e, date an pinion, dea	d place,	BALTIMORI and due to the cau	MAR use(s) and m	YLAN anner as	stated.
9b. Signature and title of certifier	uno mannor stated.		290	. License	number	-	29	d. Date signs	ed (Montt	, Day, Year)
· Mounte The	Youll !	ew	230		C.M.E	•		OVEMBE		
Name and address of person who co	1 /	(ttem 23a) (1	Type, Print)						m	
A WOODING D	· Wordy		111 F	Penn	Stre	et,	Baltimon	e, Mar	ylan	d 21201

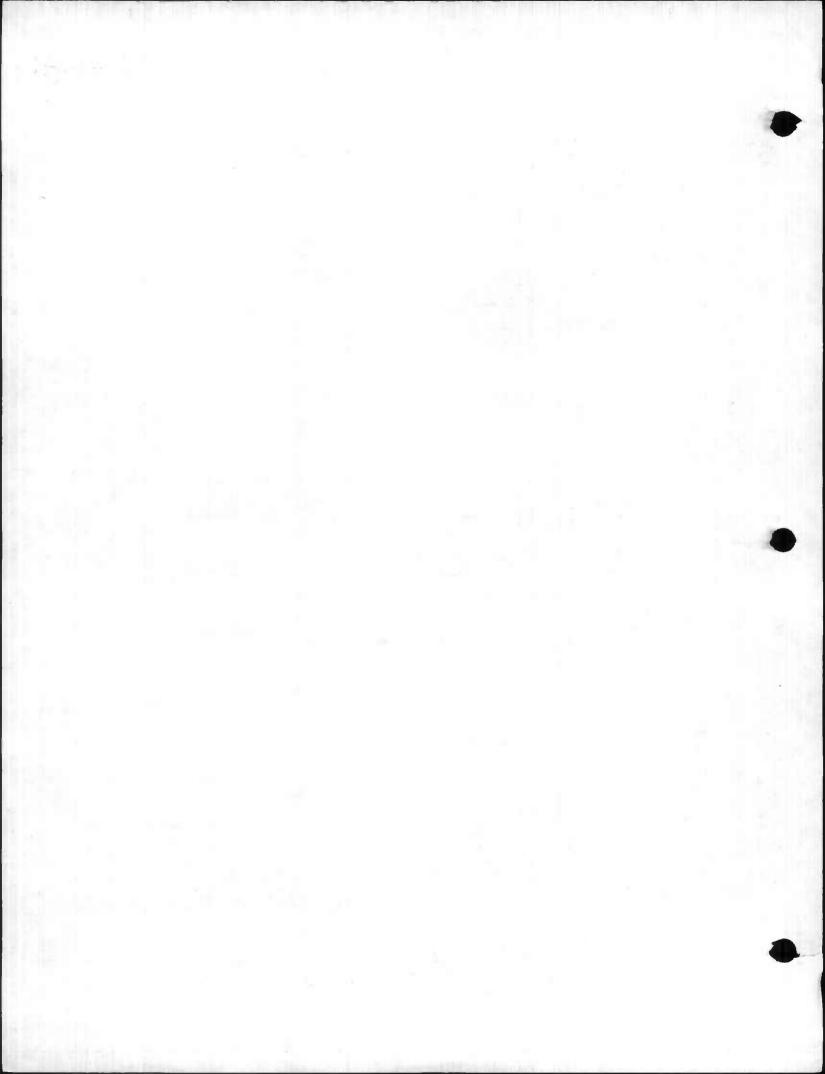
4

State Registrar

State 31. Date filed (Month, Dey, Year)
MAR 2 9 2000

32 Registrar's Signature

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth Month **Physician** December Hilda Susan Schneeman 27, 1999 10:30 P.M /Medical 4e. Facility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Potomac Valley Nursing Home Rockville Montgomery | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) | Oct. 11, 1 5. Social Sacurity Number 6. Sax 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months 75 578-22-9187 1924 Pennsylvania Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County show 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Director 1 MYas 2 □ No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? with 1235 Potomac Valley Road 20850 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Maritai Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indian, Biack, White, etc. filed within 72 hours after 1 Never Married 2 Merried 21215-0020 1 Yes 2 XNo Specify: Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Eiementery/Secondery (0-12) College (1-4or 5+) Homemaker 12 Own Home event. Maryland 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surnama) . Peges 1 and 2 should be file timent of Heelth and Mental Hent. If Item 27 Is marked oth lury or other traumatic even Be Clayton Berk McClure Viola Elliott Blume 19e. Informent's Neme/Rejetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 15808 White Rock Road, Gaithersburg, MD Charles Foster/Attorney 20878 Baltimore, Date 15, 20b. Piece of Disposition (Neme of cemetery, cramatory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State Feb. 1 Burial 2 □ Cremetion 3 □ Removel from Stata permit. Pege Department of Important: If Imp Injury or 4 ☐ Donetion 5 ☐ Othar (Specify) Parklawn Memorial Park 2000 Rockville, Maryland 21. Signatura of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00198 23e. Pert1, Enter the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or raspiratory errest shock, or heart feilura. List only one cause on each line. Approximata Intervei Betw Onset end Deeth Physician /Medical immadiete Ceuse (Final disaese or condition resulting in deeth) Cardiopulmonary Arrest Examiner Due to (or es e consequence of): Examiner Multiorgan Failure Two Weeks The law requires that the death certificate be executed buriei-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760, ettending physician for use as the burie Diabetes Mellitus Type II 30 Years Physician/Medical the Dua to (or es e consequenca of) 88 signed by the eld be detached for P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 N Unknown Division of Vital Records, à been si Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performad? page 2 has 1□ Yes 2No certificate 1 ☐ Yes 2 ☐ No after death.

Director: After this certific Be 25. Wes case referred to medical exeminar? 28. Piece of Deeth (Check only one) Hospitei: Certification: To 1 Yes 2 No Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 1 X Neturel 2 ☐ Accident 5 Pending investigetion 1 Yes 2 No the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) in by 4 - Homicide To the Hospital o within 24 hours at To the Funeral D completely filled i edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian (Check only one) 29b. Signature and/ffill 29c. Licansa number 29d. Data signed (Month. Dev. Year) D52261 December 28, 1999 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

1299 Lamberton Drive, Silver Spring, Maryland 20902

oak

State

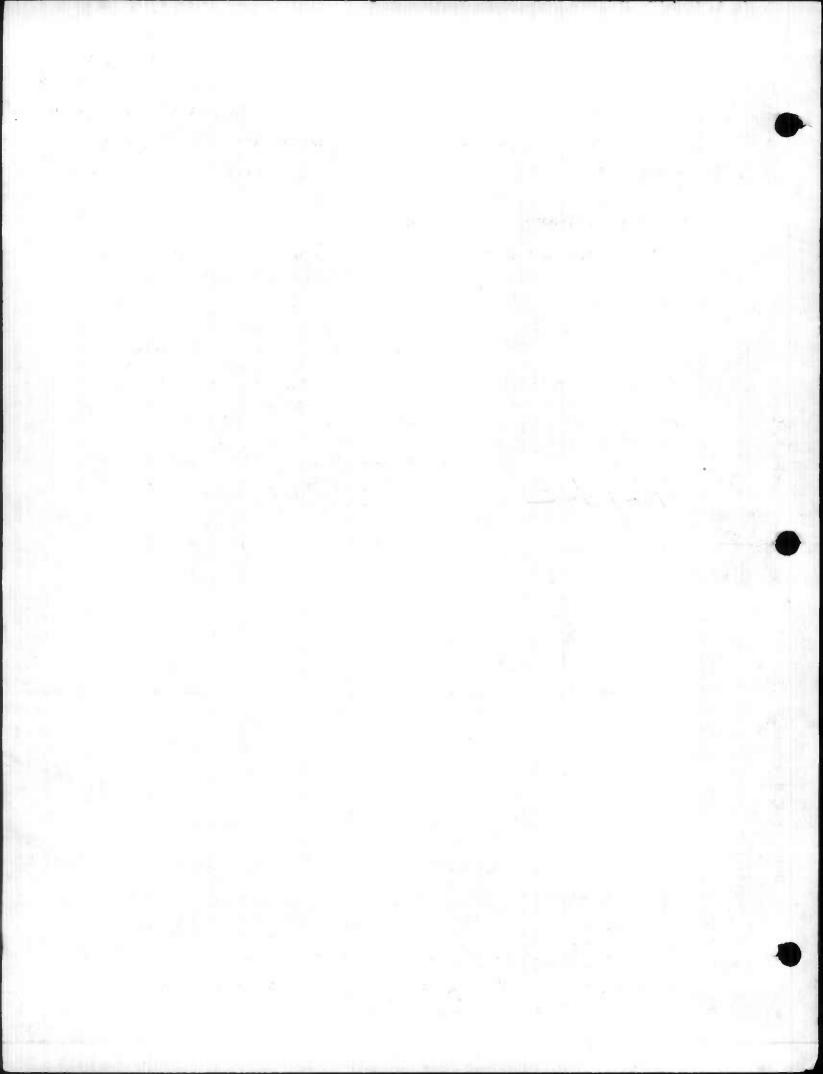
Registrar

Alan R. Segal, M.D.

FEB

31. Date filed (Month, Dey, Year)

32. Registrer's Dignature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 42887 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** Month 104 ewar tember 27, e. /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deet Examiner pita 17 Hunder 24 Hrs. 8. Date of Birth Mogth, Day, If Under 1 Yaar 6. Sex . Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Months 1 M 2 F Yrs. Director UNKNOW / Usual Rasiderice of Daceda 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Exerciper must be notified at 1 Yas 2 No Funeral Director TSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death vinent of Health end Mental Hygiene. Int: If them 27 is marked other than "natural", or hems 23s Was Decedant Evar in U,S. Armed Forces? 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. 14. Race 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifts. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Collega (1-Aor 5+) 19 1/14 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Snown 2 ewar 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) : If item 27 is or other tra la Hoville ML 20788 mother 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cremention Department 4 Donation 5 Other (Specify) 50659 70 21. Signatura of Funarel Sarvice Licensee 22. Nama and Addrass of Facility 6 Weborah Evano 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final 20 Fetal speletal dysplasia diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed **bunel-transit** Sequantially list conditions, if any, laading to immedieta cause. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medicai Dua to (or as e consequence of): signed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 XYas 2 No 1 Yas 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case retarred to medical axaminar? Be 26. Place of Deeth (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 1 Natural 2 Accidant 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation within 24 hours after death. To the Funeral Director: A 1 Yas 2 No 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar completely (Check only \$

State Registrar

31. Data tiled (Month, Day, Year) 6 2000

29b. Signature and title of certifian

32. Registrar's Signetura

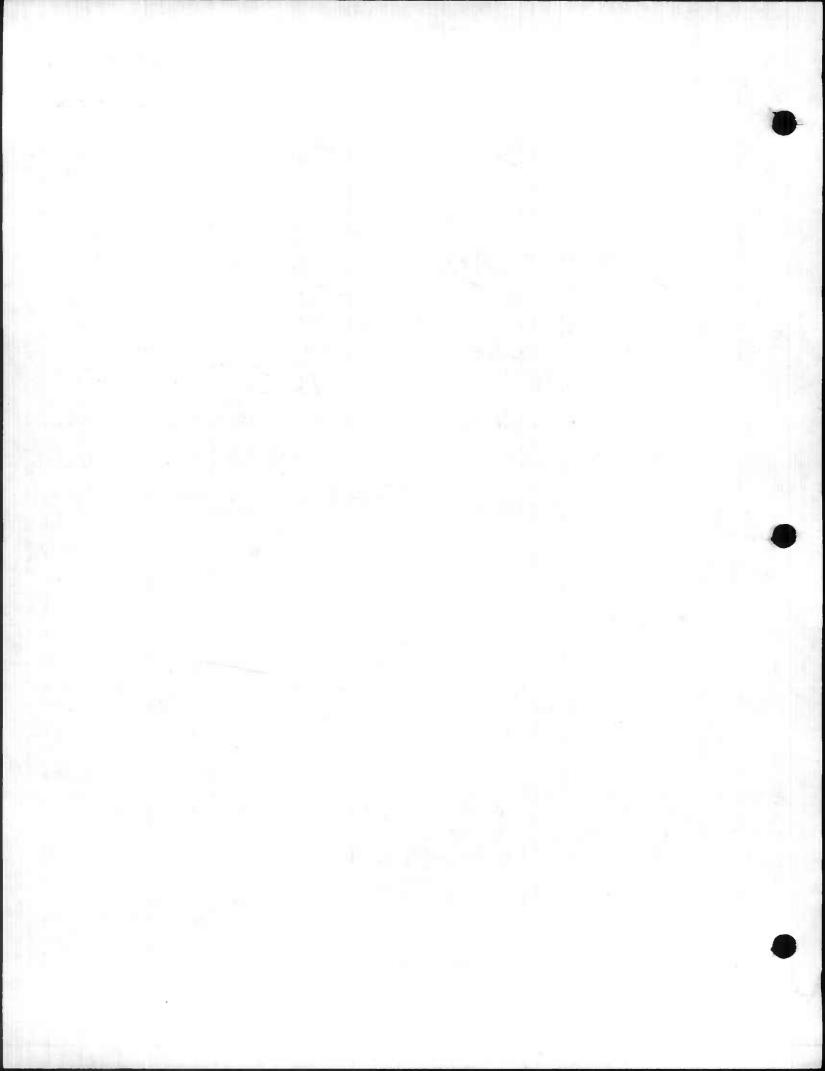
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

600

29c. License number

29d. Date signed (Month, Day, Year) 4/3/00

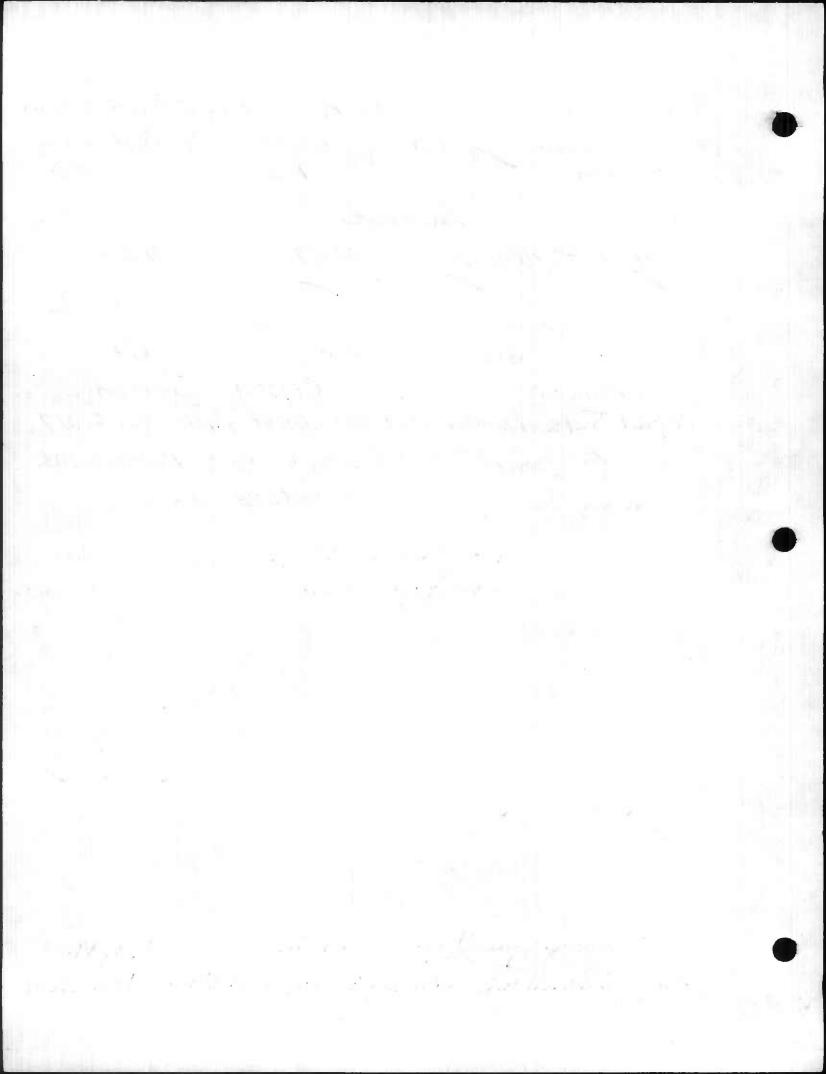
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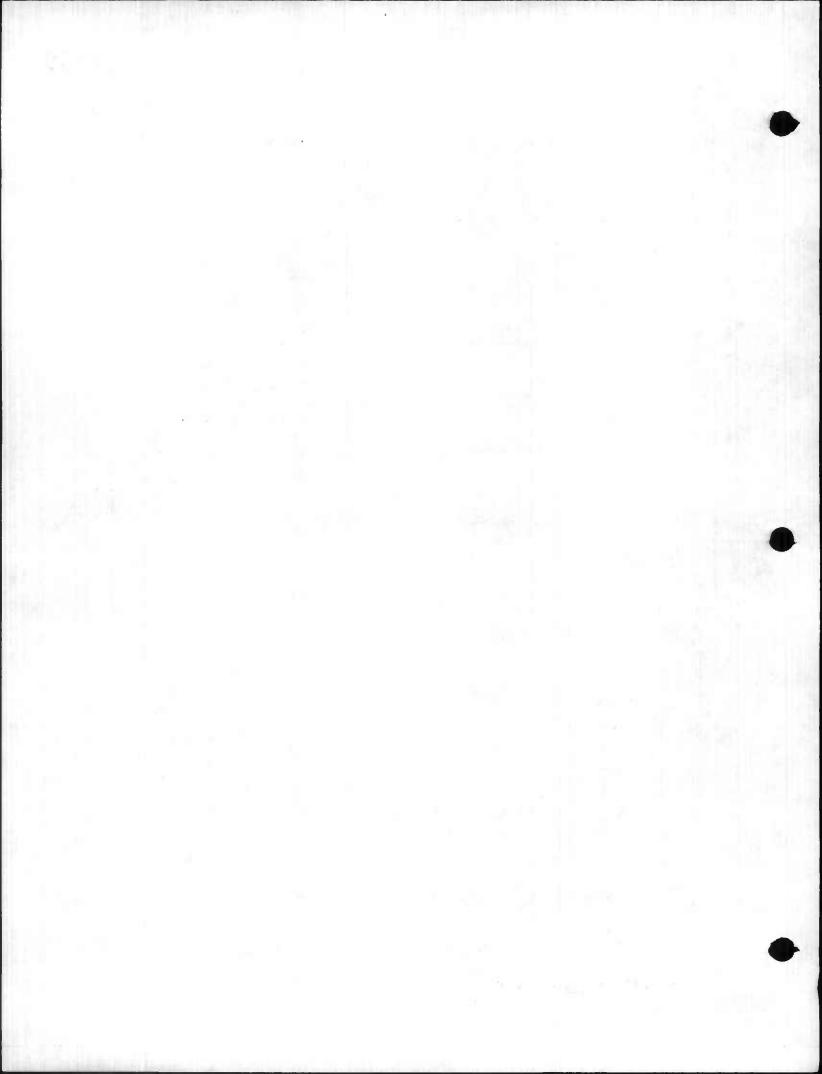
State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility Neme (If not institution, give	street and number)			r Location of Deeth	4c. County of De	ath
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Funeral	5. Social Security Number 6. So	BX T. Age (In yrs.	( last birthday) If Und Yrs.	ler 1 Year If Under 24 Hi s Days Hours Mi	n. (Month, Day, Y	ear) 9. B	inthplaca (State or Fon
Director	Usuel Residence of Decedent		*13.	1 30			IIID
Pue Maria	10a. Stete 10b. County	10c. C	city, Town or Location				10d. Inside City Lin
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with the Meryland a or 28a-1 ahow the notified at	10e. Street and Number			Zip Code	100	. Citizen of What C	Country?
23a or	1214 mc1	11/1/16 at		2/2/7		114	14
filed within 72 hours after deeth with the Me Hygiene.  With the than 'natural', or thems 23a or 28a4 a mit, the Medical Example must be notified or Completed by Funeral Director	11. Marital Startus	12. Was Decedent Ever in L	U.S. 13. Was Dec	cedent of Hispanic Origin?	(Specify Yes or No-	14. Race - An	nerican Indian,
fer des	1 Never Merried 2 Married	Armed Forces?		pedent of Hispanic Origin? Decity Cuban, Mexican, Pue	erto Rican, etc.)	Black, Wh	
or at	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1□ Yes	2 140 Specify:		Specify:	3/ack
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Department Department Important: I eny Injury o	21. Signature of Funeral Service Licens	300	22. Name	and Address of Facility			
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Physician	shock, or heart feilure. List only of	ne cause on each line.					Intervel Between Onset and Deal
/Medical	tmmediata Cause (Final	Guerra	3. 1	4.			1.1.
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thysician and the burlet transit the burlet Examiner	Sequentially list conditions.	b. Due to (	or as a consequence o				- nonce
EX P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		The state of the s				
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should be det					24a. Wes an	autopsy 24b	. Were eutopsy findi
200					-		completion of caus of death?
Page Page					1 ☐ Yes	2 No	1 Yes 2 No
certificata rector, pag	25. Was case referred to medical			26. Place of D	eath (Check only one)		
1 0 in	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ 1	DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 Other (St	pecify)
her th	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how	injury occurred	
a star death. el Director: After ted in by the funer Certification:	2 ☐ Accident investigation		M	1 Yes 2 No			
The byte	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	nome, farm, street, fecto	ory, office	28f. Location (Stre City or Town,	et and Number or i Stete)	Rural Route Number,
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in 24 hours he Funer pletaly fill edical	29a. Certifier 1 Certifying Phy	raician: To the best of my kno iner: On the basis of examina	owledge, death occurre	d et the time, date end pla	ce, and due to the cau	se(s) and manner	as stated.
Within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	one)	and manner stated.			curred at the time, date	, and place, and di	re to uid cause(s)
¥ith To th	29b. Signature and title of certifier	11	2	9c. License number	290	I. Date signed (Mo	nth, Dey, Year)
	James of	Masel !	MU.	y 15410		8/0	199.
	30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type, Print)	11 11	0 .		1
	James J. Kussi	C 6.4 113	Jeat somb	ling Hospita	Baltin	M stom	2. 2124
State	31. Date filed Mark Day, 6 2000	32 Registrar's Signa	ature 4				The state of the s
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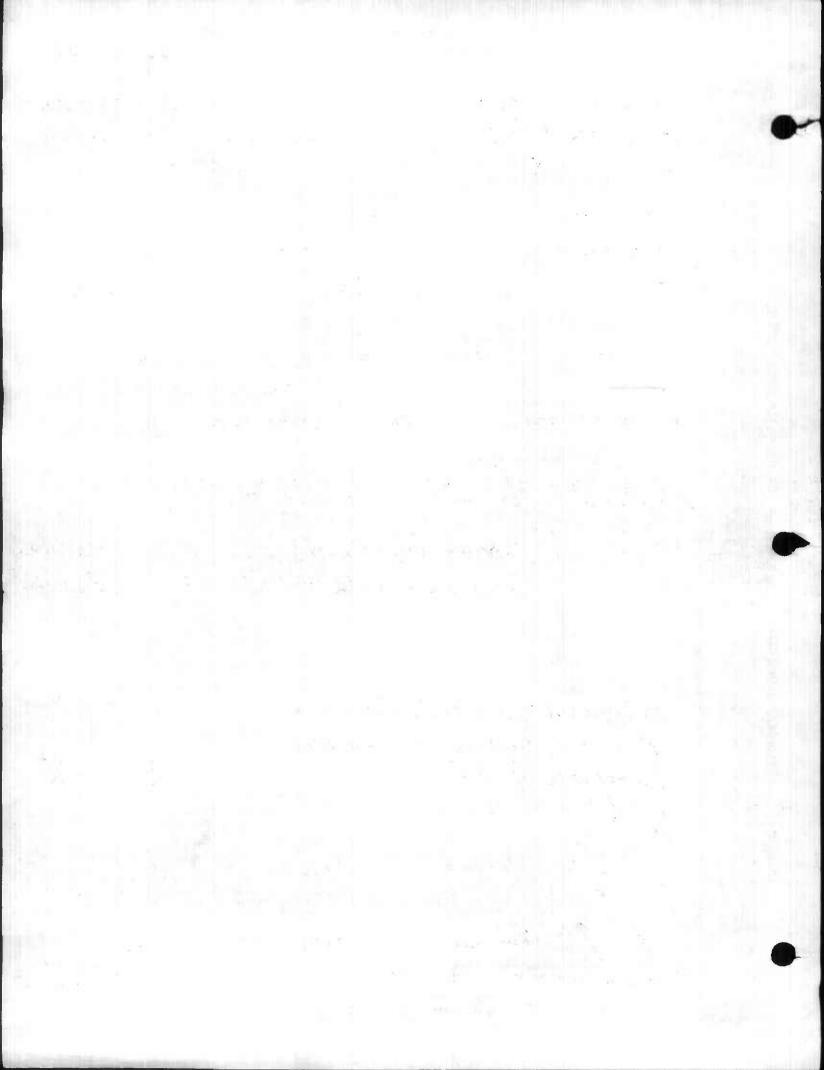


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amende		Item#21 perPHY0	3782 4/10		-		rtificate of	Death		Reg. No. 9 9	4	2889
Physician	_	1. Decedent's Name (First, Middle							2. Date of De Month	Day	Yaar	3. Time of Death
/Medical		BRENDON	JOSE			KING			OVEMBER		-	9:50 PM
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7	4	SAINT JOSEPH		-		4:44	If Under 1 Yeer	TOWSON If Under 24 Hrs.	1		IMOR	
Funeral Director		5. Social Security Number  0	6. Sex 1 ₩ M 2 □ F		e (In yrs. last	Yrs.	Months Days	Hours Min. 10	NOV. 2	th sy. Year) 28,1999	9. Birthp Cour MAR	place (Stata or Foreign htry) YLAND
show		Usual Rasidenca of Decedani 10a. Stata 10b. County			10c. City, T		ocation				1	0d. Inside City Limits
vith the Ma t or 28a-f s be notthed	-		ARUNDEL		BOWIE	Ξ	1					**
death with the Maryland rms 23a or 28s-f show rms the notified at neval Director	5	10e. Street and Number 3108 TWIGG AVE	ENUE				10f. Zip Coda 20715	5		10g. Citizan of V United		
020 urs after al., or he by Fu		11. Merital Status  1 Never Merried 2 Merri 3 Widowed 4 Divorced	Armed 1 Ya	Forces?	Evar in U,S.		Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2🌠 No	Hispanic Origin? (S an, Maxican, Puart Specify:	pecify Yas or No o Rican, atc.)		e - Amaric k, Whita, WHI	
	- Indiana	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade complete College	d) ı (1-4or 5		6a. Deced (Giva lifa.		pation during most of wor d)	king	16b. Kind of Bu		dustry
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d be find the caver	5	JEFFREY	L.		I	KING		TIANNA F			,	
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0 00		20a. Mathod of Disposition  1 □ Burial 2 □ Cremation  4 □ Donalion 5 □ Other (S)		m Stata	cam	atary, crer	sition (Name of matory or other pla DEEMER	ce)	Data 4-19-00	BALTIM		MARYLAND
Baltime permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service I	Licensaa agan M.1	٥.			2. Name and Address 01 OSLER	DR., TOV		SEPH MEI	2120	
Physician /Medical Examiner  per per per per per per per per per per		Immediata Causa (Final diseasa or condition resulting in death)		RIOA	E PREMA Dua to (or as	a consec ITIS	quence of):				1	
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UNISION  To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: Att completaly filled in by the furnity medical Certification		29a. Certifier (Check only one) Certifying 2 Medicaf I	Examiner: On tha	ha best of basis of ennar sta	axamination	dge, deeth and/or inv	n occurred at the ti vestigetion, in my	ma, data and place opinion, death occu	, and dua to the rred at the time	cause(s) and ma data and placa,	nnar as s and dua t	stated. o tha cause(s)
To the comp		29b. Signature end litia of certifiar	- h	٠,,,	-		29c. Licen:	sa number 0446		29d. Data signa		Day, Year)
	- 3	30. Nama and eddrass of person v						N. MARVI	AND 21		~ 0	//
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State Registrar		APR		>	Serve		5 4	oaks				7 13



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien 9 AMENDED ITEM #17 PER FH G782 4/17/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:25pm DAVIS EREK 09 02 /Medical 4b. City, Town, or Location of Deeth lity Name (If not Institution, give street and number) 4c. County of Death Examiner ledical Center Baltomore Cil Baltmore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Days Months Yrs. Sept 2, MD **Director** none Usual Residence of Decedent the Maryland 10b. Count 10a State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shor MD N/A Baltimore TX Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8003 Woodgate Court 21244 USA d 2 should be filed within 72 hours aftar deal th and Mental Hygiana. 7 ia marked other than "natural", or itema traumatic event, I'm Modical Exantine my 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 black by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) none none none 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) unknown CHARLES EDWARD BLACKWELL Deborah Rebecca Langley 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 st Department of Health and Important: If item 27 lain Mercy Medical Center 301 St. Paul Place Baltimore, MD 21202 20a. Method of Disposition 20b. Pieca of Disposition (Name of cametery, crematory or other pieca) 20c, Location - City or Town, Stata 1 Buriel 2 Germetion 3 Removel from State 4 Donation 5 Other (Specify) in state 21. Separture of Funeral Service Licensies Ronald S., Wade 22. Name end Address of Fecility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 ut I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Extreme Prematurity /Medical Immediate Ceuse (Finel disease or condition **Examiner** resulting in death) Examiner nding physician and usa as tha bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or tripiny that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably MATERNAL GENITAL HERPES Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Premature KuptuRE of MEMBRANES 24a. Was en autopsy Completed HIV YateRNAL or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Copatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 SNaturat 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Piaca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a Certifier complataly within 2 To the 29b. Signatury and title of of title 29d. Date signed (Month, Dey, Year) 29c. License number D0043985 30, Name and address of person who completed cause of death (Item 23a) (Typer Print) SusAn J. Dulkerian, AD.; Mercy Medical Center; 3015TPANLARE, BATTO MID 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 Depera Registrar



#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Certificate o	Health and Mental Hyg		891
wn 99-316)	2. Date of Deat		3. Time of Death 12:50 PM
treet and number) NENT & BAY	4b. City, Town, or Location of Death OCEAN CITY	4c. County of Death WORCESTER	?

/Medic Examine

Physicia

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important of Health and Mental Hyglene. Important of Hein 27 is marked other than "naturals, or he any injury or other traumatic event, the Medical Examples.

Baltimore, Maryland 21215-0020 Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1. Decedent's Nam								2. Date of				3. Time of Death
John D	oe (unl	known 99-	316)					Month DEC.		, 199	Year 99	12:50 PM
4a Facility Name (	'If not institution,	give street and nu	mber)				4b. City, Town,	or Location of De	1	c. County		
OCEAN REI	EF DEVEI	OPMENT &	BAY				OCEAN (	CITY		WORG	CESTE	ER
5. Social Security N	Number	6. Sex	7. Age (II	n yrs. last bir		Under 1 Yea			Birth		9. Birth	place (State or Foreign
unk		1 M 2 □ F			Yrs. M	ionths Days	Hours M		Day, Yea		unk	ntry)
Usual Rasidance o	of Decedent		u	nk				unk			ulik	
10a. State	10b. County		10	c. City, Town	n or Locati	on						10d. Inside City Limits
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unk						ι	ınk			ur	ık	
11. Marital Status	unk	12. Was Deci		r in U,S.	13. Was	Decedent of	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-		e - Ameri	can Indian,
1 Naver Man	ried 2 Marrie	If Yes Gi		nk		Yes 2 No				Specify	7.7	nite
	15. Decedent's	Education	u.		Decedent	's Usual Occu	patlon		16b.	Kind of Bu	siness/Ir	ndustry
(Spec		grade completed) College (	1 Ann C . )		(Give kind	d of work done NOT use retir	during most of ved)	vorking				
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17. Fathar's Nama	(First, Middla, L						18. Mother's N	lame (First, Mid	dle, Maide	n Suman	ie)	
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O.C.M.E		p (rypo, r mil)					ceet Ba			2120		, 0000)
20a. Method of Dis	position	3 □Remoyal from	State	20b. Place of cemeter	Dispositiony, cremato	on (Name of ony or other pi	ace)	Date	20c.	Location -	City or T	own, State
	5 Other (Spe		tate	7				1				
21. Signature of E	uneral Service Li	. Wade, I	lired	tor	22. N	tate Add	na Comy B	oard 65	5 W.	Balt	imor	e Street
	non	1111	1 1	11/1	12200	altimo		21201				
23a. Parti. Entar I	ne disaase, or o	omplications that only one cause on e	eusad tha	daath. Do r	not enter th	ne mode of dy	ing, such as cerd	liac or respirator	y arrest,			Approximate
shock, or hea	art failure. List o										i	Interval Between Onset and Death
Immediate Cause	/Final						cular Di		amb]	icate	ed by	
disaase or condition resulting in death)	on	a Alco	ho.]. ]	Intoxic	catio	n and	Hypother	mia			i	
			Due	e to (or as a	consequen	nce of):						
		- h									i	15.0
Sequentially list co if any, leading to in cause. Enter Under	onditions,		Due	e to (or es a d	consequen	ice of):						
cause. Enter Unde	erlying										1	
Cause (Disease or that initiated events resulting in death)	S Last	C	Due	to (or as a c	onsequen	ce of):					1	
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Part II. Other signit	ficent condition	s contributing to de	eath hut n	ot resultion in	the under	dvina cause a	iven in Pert I	23h [	oid tobacc	O USA CO	ntribute 1	to the cause of death?
		e continuous g to o		ot resoning ii	r and direct	ily ang occord g	IVOIT WITE OIL I.					bably 4 X Unknown
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								24a W	es an aut	onev	24b W	Vere autopsy findings
									arformed?		81	vailable prior to omplation of cause
								-			of	f death?
								1	X Yes	2 □ No	1	Yes 2□ No
25. Was cese refer	rred to medicet						26. Place of I	Deeth (Check or	ily one)			
examiner?	No	Hospitel:	Inpatiant	2□ ER/Ou	tpatient :	3 DOA	ther: 4 Nursin	Homa 5□R	esidence	ĕXIXIOth	er (Speci	(y) AT SCENE
27. Manner of Deat	th	28a, Date	of Injury	28b. 1	Time of	28c. tnj W	ury at	28d. Descri				,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
1 □Natural 2 □ Accident	5 Pending invastige	Found	n, Day re	Four			onk? ]Yes 2. Dono	Subje	ct ex	mose	d to	cold
3 Suicide	6 Could no	ot be 28e, Plece	2-199		m, street.	fectory, office		28f Locatio	n (Street	and Numb	er or Ru	ral Route Number.
4 Homicide	* determin	buildi	ng, etc. (S	Specify) Ma	arsh.	fectory, office Area		ment	Town, Sta	He) OCE	an R	Reef Develor in City, MD
20a Cardia	1 00 00	Dhunlele - T - "	host of				ima data and d					
29a. Certifier (Check only		Physician: To the caminer: On the be	asis of exa	amination and								
one)	t slale of	and man	ner stated	•		00= 11=	na numba-		204 5	hata si	d /8 0 a - at-	Day Vess!
29b. Signatura and		. 11					C.M.E					, Day, Year)
11/1	Are M	/ Kaid		2		0.	C.M.E			DEC.	13,	エフフフ
30 Nome and adds			al doot	/Ham 02a) /	Time Drie				4			

State Registrar

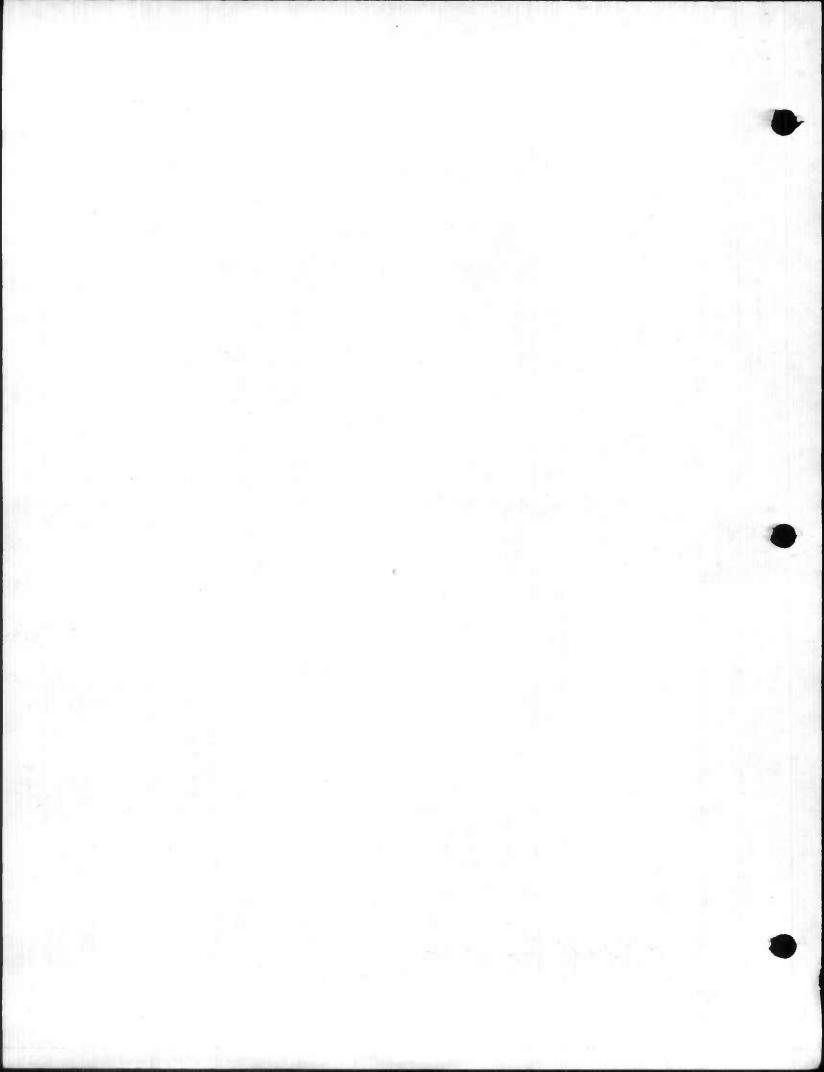
31. Data filed (Month, Day, Year)

Theodore King M.D.

APR 2 4 2000

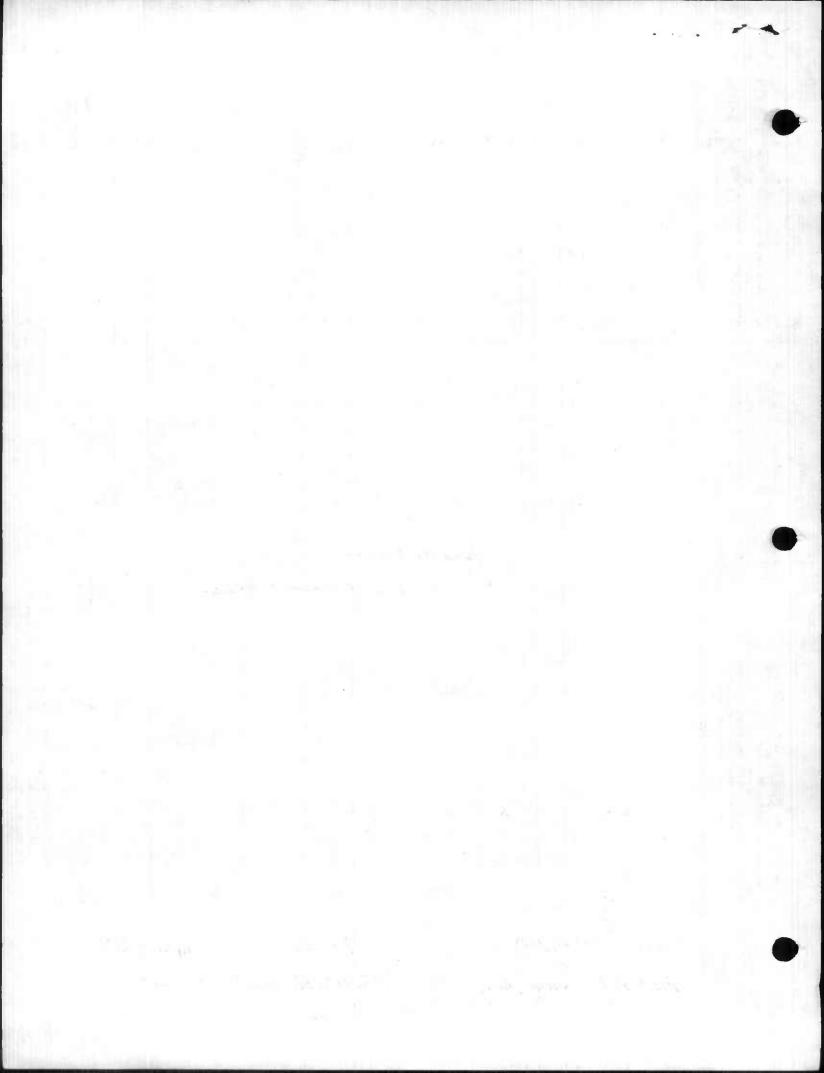
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

TORY NOT CAPTER  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation, gave stated and number?  A Positify Name of not invitation gave stated and number?  A Positify Name of not invitation gave stated and number?  A Positify Name of not invitation gave stated and number?  A Positify Name of not invitation gave stated and number?  A Positify Name of not invitation gave stated and number?  A Positify Name of not invitation gave stated and number?  A Social Security Number?  A Social Secu	_				Cert	rificate	of L	Death		Reg. No.	* **	2002
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S. Social Sourcey Number   6. Saw   10. M 28F   7. Apr (in yrs. fast binding)   Flinker 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	aminer	4a Facility Name (If not institution, give	street and number)				41	b. City, Town, or I	Location of Deat	4c. County	y of Death	
N/A   10 M 20 F   Vrs.   Monthly Days   Hours   Monthly Day   Name   Monthly Day   Name   N						M I Indos 4	Vans I					
Use State and Number   10c. Carrier		Tax office					Hours Min.	(Month, De			-	
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Source   Continue			Apt. 1C								What Coun	try?
19. Informant's Name/Fastalionship (Type, Print)   19b. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State, Zp Code)   19c. Mailing Address of Feelity   19c. Mailing Address of		1 Nevar Married 2 Married	Armed Forces? 1 ☐ Yas 2 ♣ ↑ If Yes, Give		lf.				pecify Yes or No o Rican, etc.)		ck, White,	etc.
Elementary/Secondary (0-12)   College (1-4or 5+)   N/A     Father's Name (First, Middle, Last)   Dionne Lynn Verney     19e. Informant's Name-Ralationship (77pe, Print)   19e. Mailing Address (Street and Number or Print) Route Number, City or Town, State, Zip Code)     19e. Informant's Name-Ralationship (77pe, Print)   19e. Mailing Address (Street and Number or Print) Route Number, City or Town, State, Zip Code)     19e. Informant's Name-Ralationship (77pe, Print)   19e. Mailing Address (Street and Number or Print) Route Number, City or Town, State, Zip Code)     1026 Adams Ave., Apt. 1 C, Salisbury, MD 218 (19e and Print) Route Number, City or Town, State, Zip Code)     1026 Adams Ave., Apt. 1 C, Salisbury, MD 218 (19e and Print) Route Print) Route of Print (19e and Print) Route Print) Route (19e and Address (19e and Address of Fecility Route) Route Print) Route (19e and Address of Fecility Route) Route (19e and Address of Fecility Route) Route (19e and Address of Fecility Route) Route (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address of Fecility Route) Route (19e and Address (19e and Address (19e and Address (19e and Address of Fecility Route) Route) Route (19e and Address (19e and Address (19e and Address (19e and Address (19e a	Ī				(Give k	ind of work o	done d	uring most of wor	kina	16b. Kind of B	lusinass/Inc	dustry
19. Hother's Name (Pirst, Modes, Last)   19. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State 2   20. Informant's Name/Ratalionship (Type, Print)   19b. Mailing Address (Sireet and Number or Flural Rode Number, City or Town, State 2   20. Location - City or Town, State 2   20. Location - City or Town, State 3   20. Location - City or To				+)	'lifa. D	O NOT use	retired)			27/2		
199. Informant's Name/Relationship (Type, Print)   199. Mailing Addrass (Sireer and Number or Rural Route Number, City or Town, State, Zip Code)   Dionne Lynn Carter/Mother   1026 Adams Ave., Apt. 1C, Salisbury, MD 2186 (Comment) (Print)   199. Mailing Addrass (Sireer and Number or Rural Route Number, City or Town, State, Zip Code)   Data (Comment) (Print)   200. Location - City or Town, State (Comment) (Print) (Print)   200. Location - City or Town, State (Comment) (Print)		17 Fathara Nama (First Middle Leat)	0		N/A			10 Mathada Nas	no (Einst Alidella			
196. Mailing Address (Street and Number or Rural Rode Number, City or Town, State, Zip Code)   Dionne Lynn Carter/Mother   1026 Adams Ave., Apt. 1C, Salisbury, MD 2180   120			Sr.									
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Approximation of Content (Speechy)   The Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.			er/nother	20b. Pla	ce of Disposi	tion (Nama	of					
22. Nama and Address of Fecility HOLLoway Furneral Home Professional Associ.  23. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Appoint immediate Cause (Final disease or condition and acuse) on each line.  Immediate Cause (Final disease or condition and acuse) on each line.  Due to (or as a consequence of):  Sequentially list conditions as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  24e. Was an autopsy performed?  Due to (or as a consequence of):  25. Wes casa ratered to medical asaminer?  1   Yee 2   No 3   Probably of death    26. Data of Injury    27. Nama and Address of Fecility    Appoint    Appoi									11/20/99			
Bolloway Funeral Home Professional Associance   Sol Snow Hill Rd., Salisbury, MD 21804				-I-				1	11,00,00	IICOL OI	.,	
23a. Part I. Enter the disease, or completed cause of the		0.00			Ho	llowa	y F	uneral H				
mmediate Cause (Final disease or conditions resulting in death)  Due to (or as a consequence off)  Due to (o	-	23a. Part1. Entar the disease, or comp	ications that caused		Do not enter	the mode of	of dvine	ill Rd.	Salisb or respiratory a	ury, MD	2180	4 Approximata
Due to for as a consequence of the season of		Immediate Cause (Final	Λ			12	_				1 1 1	Onset and Deal
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.   1		resulting in death)		Due to (or a	ss a consequ	0					1	
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Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yee   2   No   3   Probebly   24b. Were autop available prompletion of death?	5	Sequentially list conditions, if any, leading to immadieta		Due to 🕼 a	as a consequ	enca on:						
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of local performed?   24b. Were autopsy performed?   25b. Deate of Death (Check only one)   25b. Deate of Injury   26b. Time of Injury   26b. Deate of Death (Check only one)   25b. Location (Street and Number or Rural Route Notice one)   25b. Signeture and time to the cause of July North Check only one)   25b. Signeture and time to the best of my knowledge, death occurred at the time, data end place, and due to the cause of Month, Day, Year   26b. Deate signed (Month, Day, Year )   25b. Signeture and time to the cause of death (Item 23a) (Type, Print)   25b. Signeture and durates of person who completed cause of death (Item 23a) (Type, Print)   25b. Signeture and durates of person who completed cause of death (Item 23a) (Type, Print)   25b. Signeture and durates of person who completed cause of death (Item 23a) (T		Cause (Disaese or Injury thet initiated events	0	Due to for a							1	
1   Yes   25   No	Pa	rasulting in death) Last		Dua to (or a	is a consequ	enca ory:						
1   Yes   20   No			d									
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Magner of Death 1 Natural 5 Pending Invastigation 3 Suicida 4 Homicide Could not be determined 28a. Placa of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route North)  28a. Placa of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route North)  28a. Placa of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route North)  28a. Placa of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route North)  28b. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause and manner stated.  29b. Signeture and the of certifier 29c. License number 29d. Data signed (Month, Day, Yea April 5, 2000)  30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)	2	Part II. Other eignificant conditions cor	ntributing to death be	ut not rasult	ing in the und	lertving cau:	se give	n in Part I.	23b. Did	tobacco use co	ontribute to	the cause of d
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M-mobayus 330050 April 5, 2000  30. Nama end eddrass of person into completed cause of death (Item 23a) (Type, Print)	Š		and manner sta	iteu.		29c. L	icense	number		29d. Data signe	ed (Month.	Dav. Year)
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	-				-			,50		MPTII 3	, 2000	
Mary Beek Lindsay, M.D., PRMC 1008. CAPPOIL ST. Salisbury, MD 21801		30. Nama end eddrass of person who co				-	mall	11 1.1	L. Lukil a	11 -10	41	

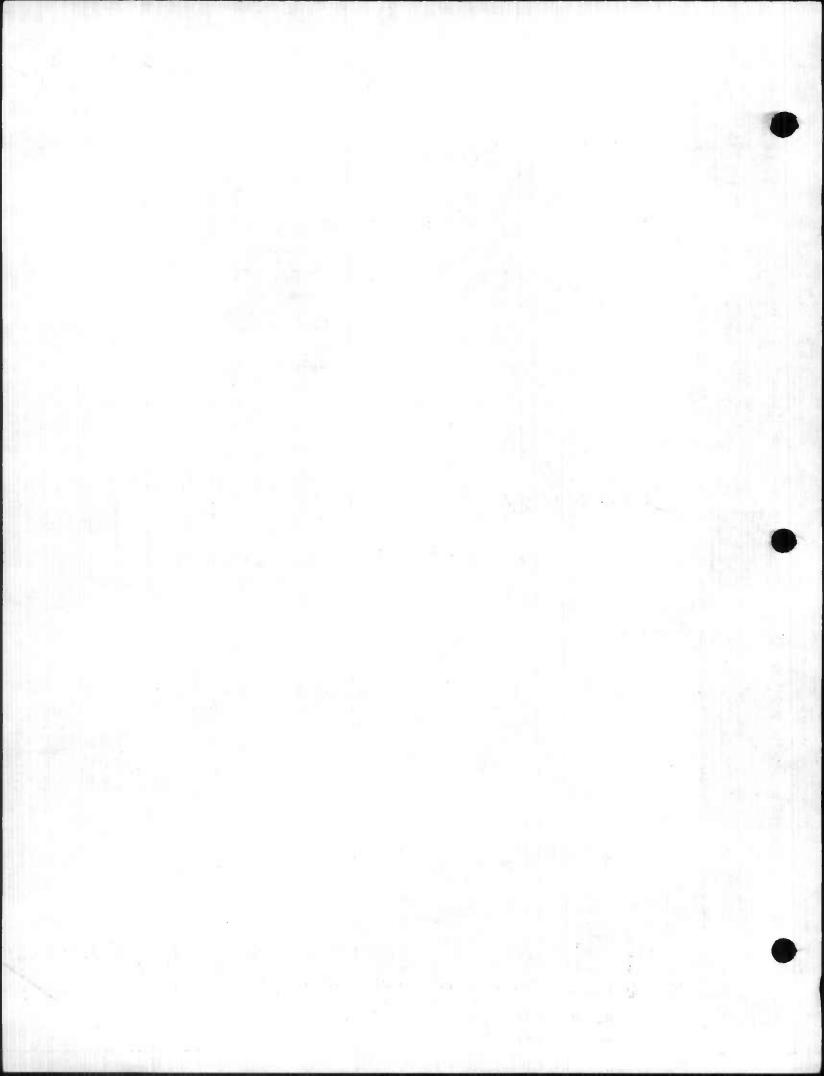


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State of Maryland / Department of Health and Mental Hygieneg 42893 Amended Item#8.9 perFHG786 8/9/2000 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Artimita Butler 07 30 1999 2:10 pm /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Prince Georges' Hospital Cheverly Prince Georges If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10M PF Months Days Yrs. 579-28-8014 Director 09-15-1916 Washington DC. Usual Residence of Decedent the Maryland 10e State 10c. City, Town or Location ahow 10b. County 10d. Inside City Limits must be notified at Yes 2□No D.C. Director Washington 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1845 Harvard Street, N.W. Funeral 20009-2347 death United States
14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) natural, or item Bleck, White, etc. 72 hours after 1 ☐ Yes 2 X No 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ₩ Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than "! Irry or other traumatic avent, the Heal Elementery/Secondery (0-12) College (1-4or 5+) 12th grade Housewife Home Maker 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Allen H. Moss Mattie L. Moss 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Farragut Street, N.E. Loretta Y. Braxton/niece Wash. DC 20017 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stets 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stele 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or page. Lincoln Cemetery 8/6/99 Suitland. Maryland 22. Name and Address of Facility Latney 'S FUNERAL HOME 21. Signature of Fullwar Service Lies CC0348 3831 Georgia Avenue, NW Wash. 20011 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel ATHEROSCIEROTIC DISEASE disease or condition resulting in deeth) Examine Due to (or es e consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 that the death certificate be Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Unknown Records, P The law requires 24b. Were eutopsy findings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Attending Physician: 25. Wes case referred to medical axaminer? 8 26. Place of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes X No this 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 2 Accident 5 Pending 1 TYes 2 No death. Investigation hours after death 6 Could not be 3 Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide ò 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier Medical completely (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 194006 30. Neme and interest of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly, Maryland 20785 Provo 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State AUG 0 9 2000 Registrar

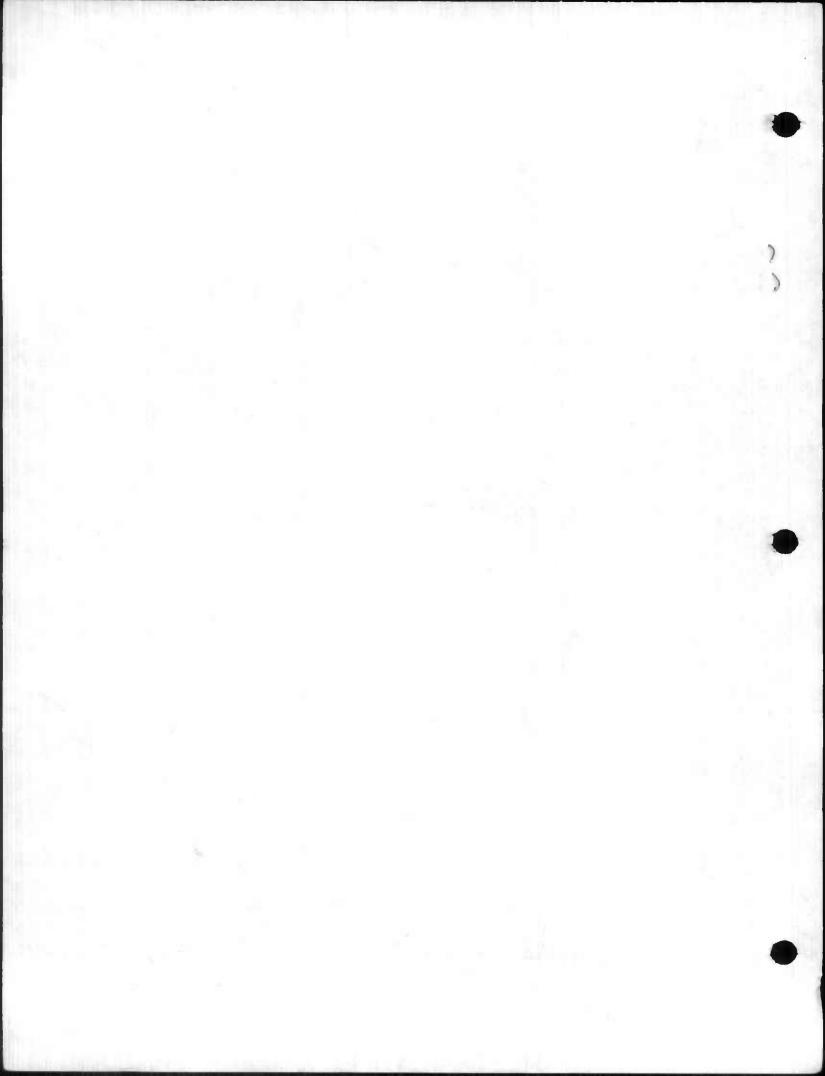
2004



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 1, 2894

				Certifica	te of	Death		Re	g. No.	14.00	
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hysician /Medical	WILLIAM HOPPE	R						Novembe:	r 30, 1	999 12:35	P.M.
miner	4e Facility Name (If not Institution, gi 7865 Crilley Roa	ve street and number d , Apartm	ent 487			46. City, To Gl.en				of Death Arundel	
al or	5. Social Security Number 214-12-3769 6.	Sex 7. A 1∆ M 2□ F	ge (In yrs. last bir 78	thday) If Und Months	Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, NOV 8,	Year) 1921	Birthplace (State or Country)     MD	Foreign
	Usual Residence of Decedent  10a State 10b. County Anne	Arundel	10c. City, Tow	or Location Glen Bu	rnie					10d. Inside City	
Direct	10e. Street and Number	1 4/.07			ip Code			10	*	Vhet Country?	
Funeral Director	7865 Crilley Ro	12. Was Deceden Armed Forces	?	13. Wes Dec	21061 edent of H ecify Cubi	lispenic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, atc.	
2	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Yaer or Detes	unk	1 ☐ Yes		Specify:			Specify		
Completed	15. Decedent's E (Specify only highest gr Elemantary/Secondery (0-12)	ade completed)  Collega (1-4or		Decedent's Us (Give kind of w life. DO NOT	ork done use retire	ation during mos d)	t of worki	ing		usiness/Industry	
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o Be	unk	,					unk				
To	19a. Informant'a Name/Relationship O.C.M.E.	(Type, Print)						more, M		Stata, Zip Code)	
	20a. Method of Disposition  1 Burial 2 Cremetion 3 [ 4 Donafign 5 10 Other (Speci		cemete	Disposition (Ny, crematory or	ame of other plac	Ce)	1	Date	20c, Location -	City or Town, State	
ਕੁਣ ਤੋਂ ਕੁਣਤ clan/Medical Examiner	23a. Pail I. Enter the diseasa, or corsholk, or heart failure. List only Immediate Cause (Finel diseasa or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury the Initieted events resulting in death) Last	a. A b. D c. d.	Due to (or as a d	oscillation of the consequence of	ero	tic	. (	or respiretory arra	lion	Approximate fintarval Betwoonset and D	veen Jeath
y Physician/	Part II. Other significant conditiona		but not resulting in		cause giv	ven in Pert	1.		bacco uss co	ntributs to the causs o	of death? Unknown
Completed by Physician/				-				24a. Was a perior Insp	ection	24b. Wara sutopsy fi available prior to completion of co of death?	ause
Be	25. Wes cese referred to medical examiner?					26. Place	e of Deat	h (Check only on	Θ)		
10	1 ⊠ Yes 2 □ No	Hospitel: 1 Inpar				4 LI NI				er (Specify) at so	ene
Medical Certification: To Be Comp	27. Manner of Death  1 Naturel 5 Panding 2 Accident investigation			Firma of njury M	28c. Inju	ryet rk? Yes 2□	No	28d. Describe he			
Certifi	3 Suicide 6 Could not determined	200. Place of II	njury - At home, fa etc. <i>(Specify)</i>	rm, sfreet, fecto	ory, office			28f. Location (St City or Town		ber or Rural Route Numi	DØF,
edicai		hysician: To the bes miner: On the besis and menner s	of examination an							enner as sfated, and dua to the cause(s	)
W	29b. Signature and title of obdiffier	tane	JM	D.		c.M.E	•	2	Aug	ust 1, 2	000
State	30. Name and audienss of person who	n Postai	death (Item 23a)  trar's Signature		n St	reet,	Bal	timore,	Maryl.a	nd 21201	



State Registrar

**DHMH 17 Rev 1/2001** 

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 3 0 2001

Theodore King M.D.

sul

32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

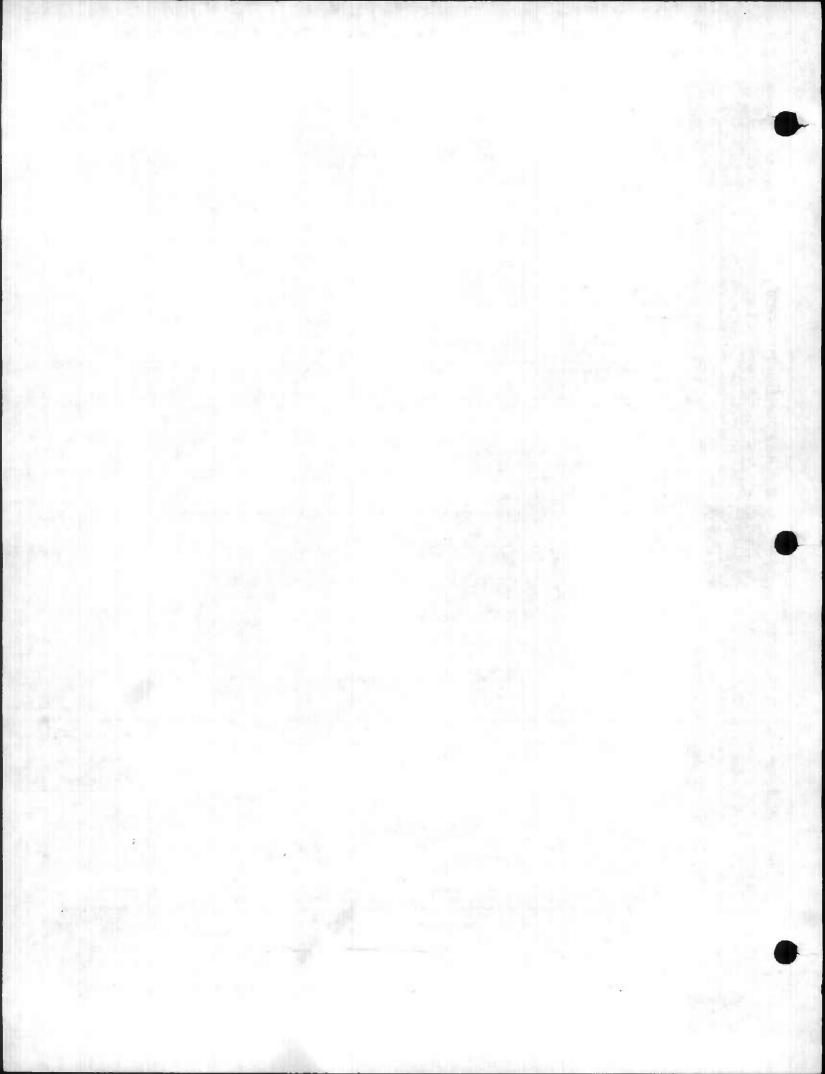
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

September 17, 1999



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) 1999 Physician. MOFFETT 29 9:40 F May BRADSHAW FLORENCE /thedical 4b. City, Town, or Location of Death 4c. County of Death 4a. Feelity Name (If not institution, give armet and number) Examiner Fallston Hurford General Hospitel Fallston 7. Age (in yrs. less birthday) | It Under 1 Year | It Under 24 birs. 8. Date of Birth | Months | Daya | Hours | Min. (Month, Day, Year) 8. Birthplace (State or Foreig Country) IDM SEF 215-01-2830 79 8/17/1919 Maryland Director Usual Residence of Decedent 10a. City, Town or Location 10d, Inside City Limits 10s. State 10b. County 1 Ves 2 No Forest Hill MD. Harford tor. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21050 U.S.A. 2118 Putnam Road 12. Was Decodent Ever in U.S. Amod Porces? 1 Yes 2 20 No K Yes, Give Year of Deles: 13. Was Decedent of Hispanic Origin? (Specify Yea or No-if Yea, specify Cuban, Mesican, Puerre Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Mertigt Statue 1 Never Memed 2 Memed 1 Yes 2 No Specify: Specify: White 5 3 Widowed 4 Divorced 10a. Decedent's Veuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4015+) Elementary/Secondary (0-12) Electronics Assembly Person 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Father's Neme (First, Middle, Last) Helen (unknown) Edward Souder 15b. Mailing Address (Street and Number or Flure! Route Number; City or Town, State, Zip Code) 19s. Informent's Name/Relationship (Type, Print) same as #10 a,b,c,e, Carl K. Moffett /Husband 20b. Place of Disposition (Name of pametery, gramatory or ather place) 20c, Location - City or Town, State 692 20a. Method of Disposition © Burlet 2 □ Cremetion 3 □R 4 □ Donetion 5 □ Other (Specify) 1999 Fallston, Marylan Providence Cemetery 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Dengemin Jarrettsville, Maryland used the death. De not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Service Onset and Death Physician vocardial Infarction /Médical DAY disease or condition resulting in death) Exammer Due to (or 64 e oor CDSIS Due to les ma e canaduance op Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Couse (Disease or injury that this tease) aris has been ilgred by the alternating physiotism and pege 2 should be detached for use as the budakter owe chemic Division of Vital Records, P.O. Box 68760, Completed by Physician/Modical Due to (of ea a consequence of) \$3b. Did tobacco use contribute to the cause of death Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. Probably 4 Unknow IDYes 20 No 24b. Were autopey lindings evallable prior to completion of cause of death? 24a. Was en sutopsy performed? To the Mapful or Allanding Physiolan: The law while 3 by hours after deeth. To the Eureri Director: After this conflictor has completely filed in by the luneral director, page 2. 2 No 1 D Yes 1 TYPE 2 No 25. Was case referred to medical evaminer? 1 Vas 2 No 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Pasidence 8 Dother (Specify) 1 Disputient 2 ENOutputent 3 DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 D Accident 28b. Time of 250. Injury of Certifications 1 Yes 2 No € □ Could not be 28e. Place of injury - At home, farm, etreet, tectory, office building, etc. (Specify) ₽ □ Buicide 28f. Location (Street and Number of Rural Route Number, City or Town, State)

08096 the completed cause of death (flem 23a) (Type, Print)

Main St. ANDREW NOWAKOWSKI 31. Date Itled (Month, Day, Year)

State Registrat 4 Homicide

29b. Signature and title of cart/lier

264. Cenfier

Medica

32. A gistrare Signature JUN 3

Cordifying Physician: To the best of my knowledge, death occulred at the time, date and place, and due to the cause(s) and menner se steled.

EL Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

28d. Date signed (Month, Day, Year)

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		- State Registrar					Ce	rtificat	te of L	Jeath			Reg	. No.	77-	- 71	CB71
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xaminer		4a. Facility Name (If n	not institution,	, give stree	and numb	er)		4b. City,	, Town, or	Location	of Death			4c. C	County of I	Death	
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McGHEE		1 - For Stete Registrar	State	of Marylan		artment of rtificate of		h	R	leg. No.	79-9	12898	
Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Death											
/Media		Jacob McGhee APRIL  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							4c. Cou	1990 unty of Death			
Examin	er	PRINCE GEORGE'S HOSPITAL CENTER							PRINCE GEORGE'S				
Funeral		5. Social Security Number	7. Age (In yrs.		CHEVERLY  If Under 1 Year   ff Under 24 Hrs.    Months Days Hours Min.			B. Date of Birth (Month, Day, Year)  9. Birthplace (State or F Country)			place (State or Fore		
Director		None	1)X) M 2□ F		Yrs.	Yrs. 7			Sept. 4,		1998 Maryland		
pu ,		Usual Residence of Decedent 10a, State 10b, Cou	nhy	10c Cit	ty, Town or L	ocation						10d. Inside City Lin	
ehow	2		00%									1 🗓 Yes 2 🗆	
or 28a-f	Director	MD Pri	nce George	's Ch	neverly	10f. Zfp Code			-	10a Citizen	of What Cou	intov?	
death with the Maryland ms 23a or 28a-f ehow must be notified at						20784				U.S.A.			
ns 23a	Funeral	11 Marital Status 12, Was Decedent Eve						Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)			14. Race - American Indian,		
	Completed by Fun	1 ☑ Never Married 2 ☐ M	Armed tarned 1 ☐ Ye	ff Yes, Give Year or Dates:  is Education grade completed)  Cottege (1-4or 5+)		If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2√Ω No Specify:			can, etc.)		Bfack, White, etc.		
within 72 hours after death with the Maryla ane. Itsn "natural", or items 23a or 28a-f ehor he Madical Expressions must be rivilliad at		3 Widowed 4 Divor	ff Yes.								Specify: White		
		15. Dece (Specify only his	dent's Education			edent's Usual Occi	Usual Occupation of work done during most of working		,	16b. Kind o	. Kind of Business/Industry		
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754		<b>V</b>	M- 1 A)			None	10 140	18. Mother's Name (First,					
o a p >	To Be	17. Father's Name (First, Mide Unknown	Ne, Last)					na Lynn l		Marueri Sur	maine)		
should Ind Meni			nachia (Tima Brint)			ing Address /Ctra		lumber or Rural Route Number,		e City or To	City as Town State Tip Code)		
i 1 and 2 sho Health and I tem 27 is ma other treuma		19a. Informant's Name/Relati		(Mother)		Madison Way osition (Name of matory or other plan						(p COO6)	
f Healt item 2		Ramona Lynn McGl 20a. Method of Disposition	lee (Mother)					Date	Georges			Town, State	
permit. Pages 'Department of himportent: If ite eny injury or of ance.		1 X Buriaf 2 ☐ Cremati					lace)		00	Washington, D			
t. Partimer		*4 □Donation 5 □Othe				Cemetery	rass of Ea	4/26/19	99	wasnin	gton, DC		
Department of the population o		21. Signature of Funeral San Duplicate Ce business No	rtificate,FH	no longer	in É	in Plunkett Fu		neral Home t N.E. Washing		acton DC			
The law requires that the death certificate be executed and the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	quence of): quence of):										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnat 1   Live birth 2   Feta 4   Pregnant at time of d 9   Unknown				al death 3 Ectopic pregnancy					23d. Date of delivary Month Day Year		
w requires that been signed I should be det		Part II. Other significant con	sulting in the underlying cause given in Part I.					e. Did tobecco use contribute to the cause of death					
	Complet									As an utopsy endomed? s 2 No 24b. Were eutopsy findings av. prior to completion of cau death?  Yes 2 No			
Physician: Th r this certificate ral director, pag	Be (												
d is	To	1 X Yes 2 □ No	Hospital: 1   Inpatient   MER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)								cify)		
Jing Ph After th funeral	on:	27. Manner of Death 1 □Natural 5 □ Pe	/4						28d. Describe how injury occurred				
	cat	Z COOLOGIT		APRIL 17, 1999			1:00 1 Yes 2 No		UNKNOWN  28f. Location (Street and Number or Rural Route Number,				
or At itter d Direct in by	Certification:	3 Suicide 6 Could not be determined 28e, Place of Injury - At home, building, etc. (Specify)				, and the state of			City or Town, State) 5456 MADISON W				
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Hospital or Attending the Hours after death Funeral Director: etely filled in by the	edical	(Check only Mad	cal Examinar: On th	e basis of examin	nowledge, dea nation and/or	ath occurred at the investigation, in m	y opinion,	and place, ar death occurre	d at the time,	date and pla	ace, and due	to the causa(s)	
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	one) and manner stated.							29d. Date s	Date signed (Month, Dav. Year)			
T X O		1/9 1 0 1 0 0 1								29d. Date signed (Month. Day, Year) REISSUED			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								MAY 8	Y 8, 2002		
		Theodore King		acoo or obelia (ile		1 Penn S	treet	, Balt	imore,	Mary.	land 2	1201	
	ate	31. Date filed (Month, Day, Y		2. Registrar's Sign	nature	B - 7		,					
Regist	rar	M/	Y 1 7 2002	P Diese	-	0 20	acks						

DHMH 17 Rev 1/2001

2005 to 1 YAM

. Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 11 Decedent's Name (First, Missie, Last) LEATHER 3.40 Am Physican April LORRAINE ARVILLA 28 4b. City, Town, or Location of Death ec, County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Western Maryland Hospital Center # Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 13, 1921 6. Sex 10 M 20 F 9. Birthpiace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Furnish Marilland 78 Ynt. 214-14-6109 Direction 10d. Inelde City Limits 10s. State 10b. County 10c. City. Town or Location 1 Yes XO No Director Hagerstown Washington Md. OF 28th 10g, Citizen of What Country? 10e. Street and Number 101. Zip Cede 21742 13619 Little Antietam Rd. U.S.A. Furnaral 13. Was Decedent of Hispanic Origin? (Specify Yea or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Markel Status 1 Yes 2 No 1 Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 Tee 20 No Specify. Maryland 21215-0020 specity: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give land of work done during most of working IBs. DO NOT use retred) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker pernit. Pages 1 and 2 should be tea Department of Health and Marial Hy Important: If Heal 27 is mariaed othe Bry Nelvery or other insurance event SIDS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 David Finley Weaver Maude Gray Warbel 2 19s. Informant's Name/Relationship (T)/pe, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Leather (Husband) 13619 Little Antietam Rd. Hagerstown, Md. 21742 20s. Method of Disposition 20b. Place of Disposition (Name of cometery, cramatory or other place) 20c. Location - City or Town, State A COther (Specify) Rest Haven Cemetery May 3,1999 Hagerstown, Md. 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 that caused the death. Do not enter the mode of dying, such as cerdies of Physician /Lindical Ineum onia 3-4 week Examiner Physician/Medical Examiner Stage Re Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Iriyary control loss for the control of the cause (Disease) Division of Vital Records, P.O. Box 68760, led evenis in death) Last Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 255. Did tobacco use contribute to the seuse of death? 1 Yes 2 No 3 Probably 4 Union mised Nutitud Status 24b. Ware autopsy findings available prior to completion of cause of death? 24s. Was an autopsy performed? 1 Yes 2 No 1 1 Yes 2 No 25. Was case referred to medical 26, Place of Death (Check only one) Hospital: 2 EF/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Alber Stin 27. Manner of Death Certification: 26a. Date of Injury (Month, Day Year) 280, Injury at Work? 28d, Describe how injury occurred 1 Natural 2 Accident 1 Yat 2 No 6 ☐ Could not be 3 Subside 28a. Place of injury - At home, larm, etreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) clan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

or: On the basis of anamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title, of partifier 29c. Libense number 29d. Date signed (Month, Day, Year) D34165 April 28th, 1999

auso of cleath (from 23a) (Type. Print) WESTERN MARYLAND HOSPITAL CENTER

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1500 PENNSYLVANIA AVE HAGERSTOWN MD. 21742

DHMH 16 Rev 6/06

State

Registrar

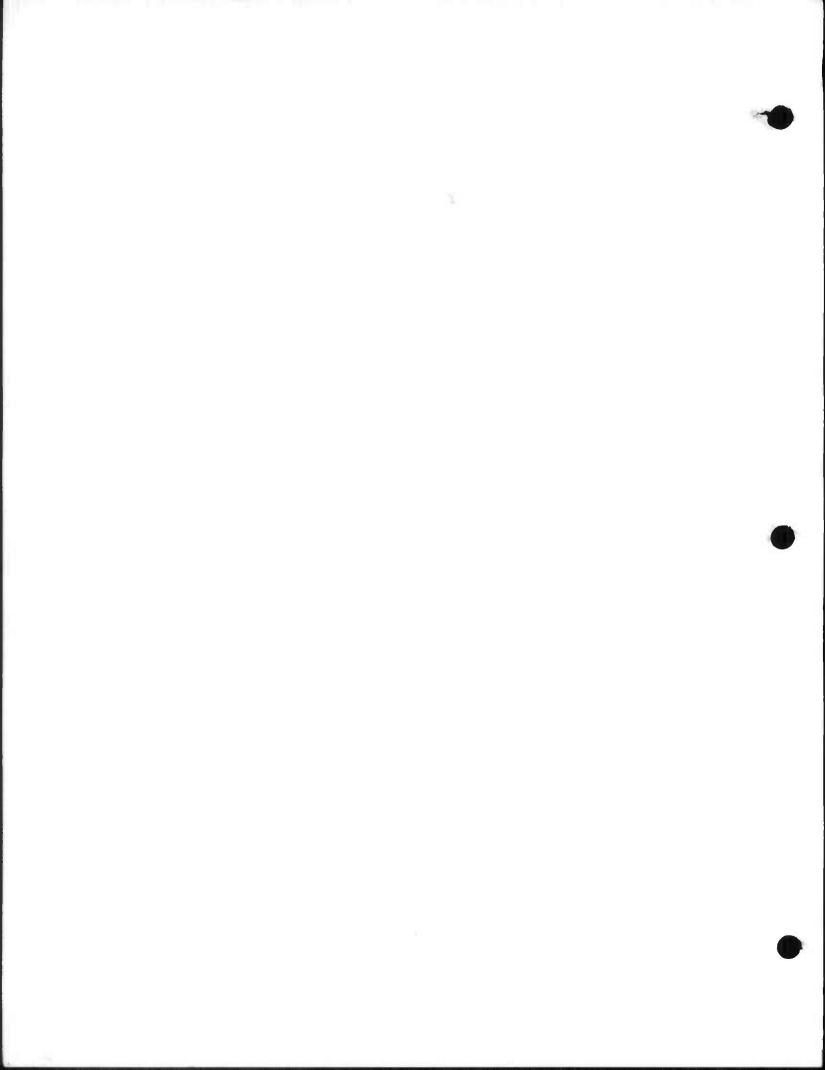
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MAY 07 1999

31. Date filed (Month, Day, Year)

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32 Augistrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 4b. City, Town, or Location of Deeth 4c. County of Death 0740 REIB MARIAN /Medical 4e. Facility Neme (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Birthpiece (Stete or Foreign Country) **Funeral** Months Deys Hours 190-48-463 1□ M 2\F 88 Yrs. Director PA Usuel Residence of Decedent the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show Exeminer event be notified at 1 ☐ Yes 2 No Director MD. MICOMICO PITTSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5250 Morris Road 21850 Funeral U.S.A 4. Rece - American Indien, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: by Specify: 36 Widowed 4 □ Divorced WHITE Completed Peges 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturury or other traumatic evant, the Mexical Lay or other traumatic evant, the Mexical Lay. 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be POLEY WILLIAM IRENE 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Piece of Disposition (Name of cametery, cremetory or other place) ELIZABETH SHOWALTER 20e. Method of Disposition important: if its any injury or o 1 ☐ Buriel 2 ØCremetion 3 ☐ Removel from State **Depertment** 4 ☐ Donetion 5 ☐ Other (Specify) 8-24 SALISBURY CREMATORY SALISBURY, MD. 21. Signature of Funeral Serui 22. Neme end Address of Fecility ULLRICH FUNERAL HOME BERLIN, 23a. Per 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** · Gastrointestinal homorrhage, acute /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Gastric / duodenal alcers Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest P.O. Box 68760 Physician/Medical Due to (or es e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director. 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division Neturai 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piace, end due to the cause(s) end menner steted. edicai 29a. Certifier To the 29c. License number
D 00 54 997 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) anne 8-23-99

SALIS WAY,

551 RIVERSIDE Dr

State

Registrar

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

I.R. Michael Darnell 55

2007

Registrer's Signature

31. Dete filed (Month, Dey, Year)

FEB 09

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02/09/2007 Certificate was misfiled in the Worcester County Health Department Certificate was never filed nor registered.
Certificate filed today. okayed by Ms. Sparks

Certificate of Death 1. Decedent's Neme (First, Mittele, Last) 2. Date of Deal William Kemp Richardson, Sr. May 27 1999 2:42 a: se Facility Name (If not insultation, give street and number 4s. City, Town, or Location of Death 40. County of Dust 131 South Washington Street Havre de Grace Harford 6.3ez 1MM 20F 5. Social Security Number 8. Birminos (State or Foreig Courty) Y/B. 220-20-0496 87 MD 05/28/1911 10a, State 10b. County 10c. City. Town or Lecation. 10st Inside City Limite 1 Yay 20 No MD Harford Havre de Grace 10m Street and Number 10f Zlo Code 10g. Citizen of What Country? 131 South Washington Street 21078 USA 12. Wee Decedent Ever in U.S. Armed Ferces? 11 Martial Status 13. Was Decedart of Hispanio Origin? (Specify Yee or F if Yes, specify Cuban, Misston, Puerto Floan, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 20 Married 1 Yes 2 No If Yes, Gro Year or Octoo: 1 Yes 2000 Specify: 3 DWIdowed 4 D Diversed speaky: White 18. December & Education (Specify any highest grade completed) 16s. Deladers Usual Occupation (Cirkless of york done during mass of working sts. bp NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cologo (1-tor da) Tith Warehouse Supervisor Government 17, Father's Name (First, Mittile, Last) 18. Mother's Name (Find, Albaha, Maken Sumemo) Charles Alexander Richardson Florence Hackney 18s. Informant's Name/Relationship (Type, Pres) 19b. Meking Address (Street and Mymber or Rural Route Humber, City or Town, State, Zie Code) 31 S. Washington St., Havre de Grace, MD 21078 Evelyn D. Richardson- Wife 20s. Place of Dissociation (Name of complete, crematery or other place) 20s. Methog of Disposition 20c. Lecation - City or Town, State Date I ABurial 2 Commetter 3 Demoval from Since 4 Donesion 8 Other (Specify) Angel Hill Cemetery 5/29/99 Havre de Grace, MD 21. Signature of Europai Service Upenser Mitchell-Smith Funeral Home, P.A. 1723 S. Washington, Havre de Grace, MD 21078 immediate Cause (Final disease or condition resulting in death) with Metastasis Setuentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Deesse or Injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of di Part II. Other significant conditions contributing to deem but not requiring in the underlying cause given in Part I. 10 Yes 20 No 30 Probably 20 Unitro Chronic Rend Insufficien 24s. Was an europey performed? 1 Yes 250 Ho 1 Yes 2 No 25. Was case reterred to medical significant 26. Place of Death (Check only one) Hospitel, 1 | Impattent 2 | EFVOvement 3 | DOA | Other, 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 200 27. Manner of Death 264. Describe how injury eccurred 290. Time of 28c. Injury of 20a, Date of Injury (Mene), Day Year) 5 Pending IDYM ZONO 2D Appldum 28f. Location (Errest and Number or Rural Rouse Number, City or Town, State) € □ Could not be A C Suicide 286. Place of Injury - Al home, farm, street, lastory, office building, ero. (Speedy) 4 1 Hamirade 1 Contriving Physicien: To the best of my knowledge, deem occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physicien: To the best of examination and/or investigation, in my opinion, deem occurred at the time, date and place, and due to the cause(s) and manner stated. 29e Certifier 29c. License number 294; Date signed (Money, Day, Year) 29b. Signature and title of certified D43115-5-28-99 1324 Mirra A. Bais 30. Name and addrage of person who completed cause of death (Hem 23s) (Type, Print) Haurebe Marsi 32, flogistrar's Signatora Date filed (Month Day, Year) MAY 27 1999

State of Maryland / Department of Health and Mental Hygiene

